

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05076

05074

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg R # 2</u> c. LENGTH OF STAY IN b. <u>22 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cavetown-Boonsboro Pike</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg R # 2</u> d. STREET ADDRESS <u>Cavetown-Boonsboro Pike</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WESLEY</u> Last <u>AMBROSE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2 1888</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George L. Ambrose</u>				14. MOTHER'S MAIDEN NAME <u>Emma Hose</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>220-34-0904</u>	
17. INFORMANT <u>Mrs Emma E. Ambrose Smithsburg R # 2</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>Arterio Sclerosis (generalized)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	
20g. (State)		21. I certify that (I) (this hospital) attended the deceased from <u>March 30, 1962</u> to <u>April 22, 1962</u> that (I) (we) last saw the deceased alive on <u>April 22, 1962</u> and that death occurred on <u>April 23, 1962</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. G. Kohler</u>				22b. DATE SIGNED <u>April 23 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>G. A. KOHLER</u>			
22d. ADDRESS <u>Smithsburg Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
23b. DATE THEREOF <u>4/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown Wash Co Md.</u>		23e. REC'D BY REGISTRAR			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				25a. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>		25b. DATE <u>APR 26 '62</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 6 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) JACKSON CONVALESCENT HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1515 PARK ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) BERTHA MAE ANGLE		4. DATE OF DEATH Month APRIL Day 4 Year 19 62	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 15 1882
9. AGE (in years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY FRANKLIN PENNSYLVANIA	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME COMMODORE F LOWMAN		14. MOTHER'S MAIDEN NAME MARGARET YOUNG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS MAE ANGLE HAGERSTOWN MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-122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3-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-24			

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RECEIVED
JAN 10 1962
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: DIRECTOR, A.R.S.
FROM: ASSISTANT SECRETARY, A.R.S.
SUBJECT: [illegible]
DATE: [illegible]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05078		Item 8 Film G312 5/8/62 iwk		05076	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>Month</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hosp.</u>		d. STREET ADDRESS <u>539 Columbia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES Otha BAGENT</u>		4. DATE OF DEATH <u>APRIL 29 - 1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888 March 3, 1887</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown MD</u>	
13. FATHER'S NAME <u>Jacob H. Bagant</u>		14. MOTHER'S MAIDEN NAME <u>Anna Miller</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-5714</u>		17. INFORMANT <u>Mrs. Charles O. Bagant</u> Address <u>Cumb. MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> 177X DUE TO (b) <u>generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO (c) <u>carcinoma of prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>unknown</u> <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (the physician) attended the deceased from <u>4-6-62</u> , 19 <u>62</u> , to <u>4-29</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4-29</u> , 19 <u>62</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Victor L. Ramos,</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>April 30, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>		22d. ADDRESS <u>1500 Pa Ave Hagerstown MD</u>			
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/3/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memo. Pk.</u>	23d. LOCATION (City, town or county) <u>Cumberland MD</u> (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. MD.</u>		25a. REC'D BY REGISTRAR <u>MAY 3 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

(M)

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15078

STATE OF TEXAS

County of ...
State of Texas
I, the undersigned, Clerk of the County of ...
do hereby certify that the within and foregoing is a true and correct copy of the ...
as the same appears from the records of the County of ...
this 11th day of ... 1907

Witness my hand and the seal of the County of ...
at the City of ... this 11th day of ... 1907

By the Clerk of the County of ...
[Signature]
Clerk of the County of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05079

05077

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Md. State Hospital		d. STREET ADDRESS Route 5	
3. NAME OF DECEASED (Type or print) First MIDDLE Last SUSAN BARBER		4. DATE OF DEATH Month Day Year APRIL 28 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1874
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Adams Co. Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leonard Wyssinger		14. MOTHER'S MAIDEN NAME Mary Long	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs. Simon Summers		Address Hag. Rt. 5	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) GENERALIZED ATHEROSCLEROSIS (c) DUE TO SUBACUTE AND CHRONIC PYELONEPHRITIS		INTERVAL BETWEEN ONSET AND DEATH FEW HOURS UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-19-1961, to 4-28-1962, that (I) (we) last saw the deceased alive on 4-28-1962, and that death occurred at 8:15 PM, from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Palladrosi		22b. PHYSICIAN'S NAME ANTONIO U. PALLADROSI	
22c. PHYSICIAN'S ADDRESS 1500 Pa Ave Hagerstown MD		22d. ADDRESS 1500 Pa Ave Hagerstown MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-62	
23c. NAME OF CEMETERY OR CREMATORY Shiloh U. B. Cemetery		23d. LOCATION (City, town or county) (State) Fiddlersburg. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR DATE MAY 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

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VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05080
CERTIFICATE OF DEATH
05078

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEWSVILLE c. LENGTH OF STAY IN TB 18 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NO STREET ADDRESS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEWSVILLE d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIE SEIBERT BECK		4. DATE OF DEATH Month Day Year APRIL 4 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 31 1872
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) FRANKLIN PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CONRAD SEIBERT	
14. MOTHER'S MAIDEN NAME BARBARA FRIESE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS JOHN W CABLE JR CHEWSVILLE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-1-1962 to 4-4-1962 , that (I) (we) last saw the deceased alive on 4-3-1962 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE E.W.DITTO JR. M. D.		22b. DATE APRIL 6 1962	
22c. PHYSICIAN'S NAME (Type) E.W.DITTO JR. M. D.		22d. ADDRESS 215 W WASHINGTON ST. HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-6-62	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY	23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR DATE APR 10 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Hanna

02020

(M)

[Handwritten signature]

1944. 11. 1.

WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF THE ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05081 CERTIFICATE OF DEATH 05079

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Mt. Airy</u> d. STREET ADDRESS <u>RD#3, Penn Shop Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arville</u> <u>Bridges</u> First Middle Last 4. DATE OF DEATH <u>April 14</u> , 19 <u>62</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 27, 1881</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Buildings</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Campbell Co., Tenn.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William H. Bridges</u> 14. MOTHER'S MAIDEN NAME <u>Catherine Foust</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>214-16-1484</u> 17. INFORMANT <u>Mr. Ollie Bridges, New Market, Md.</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia, bilateral</u> 331X DUE TO (b) <u>cerebro-vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>general arteriosclerosis</u> DUE TO (c) <u>general arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVA. BETWEEN ONSET AND DEATH <u>3 days</u> <u>9 years</u> <u>20 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>April 15</u> , 19 <u>62</u> to <u>April 14</u> , 19 <u>62</u> that (1) <u>(me)</u> last saw the deceased alive on <u>April 14</u> , 19 <u>62</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Victor L. Ramos</u> , M.D. 22c. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, M.D.</u>		22b. DATE SIGNED <u>April 14, 1962</u> 22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/17/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Meth.</u> 23d. LOCATION (City, town or county) (State) <u>Clagettville, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. W. Smith</u> 25a. REC'D BY REGISTRAR <u>April 18 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Carleton S. House</u>	



1
FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05080

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 57 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 27 N. Locust	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry Clayton Carper				4. DATE OF DEATH Month Day Year April 14 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1897	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Store		11. BIRTHPLACE (State or foreign country) White Post, Vs.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albert Carper				14. MOTHER'S MAIDEN NAME Elizabeth Grubbs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-0805		17. INFORMANT Address Mrs. Dorothea C. Carper Hag. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4-5-64 DUE TO <u>Pulmonary Congestion & Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis, Severe</u> DUE TO (c) <u>Cardiac Hypertrophy</u>							INTERVAL BETWEEN ONSET AND DEATH Recent
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. W. Ditto, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED April 14, 1962			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-62		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR Scott F. Minnich & Son Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE APR 17 '62		24b. REGISTRAR'S SIGNATURE Arthur S. f.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR AIS [4]
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05083
CERTIFICATE OF DEATH
05081

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 357 Ridge Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE ELVIN CONDON		4. DATE OF DEATH Month April Day 23 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25 1898	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		12. KIND OF BUSINESS OR INDUSTRY Self Employed	
13. FATHER'S NAME William Condon		14. MOTHER'S MAIDEN NAME Nora Sease	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-5886	
17. INFORMANT Mrs Pauline V. Condon		Address 357 Ridge Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (b) 2 yrs (c) 2 yrs DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Open heart disease (b) General arteriosclerosis (c) prostate hypertrophy, benign		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 28, 1960 to Apr 23, 1962 that (I) (we) last saw the deceased alive on Apr 22, 1962 and that death occurred at 5:22 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Edward V. Ditto III		22b. DATE SIGNED APR 26 '62	
22c. PHYSICIAN'S NAME (Type) Edward V. Ditto III, M.D.		22d. ADDRESS 217 N. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/62	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR APR 26 '62	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Charles L. Hume	



1 FOR STATE HEALTH DEPT.

TO DIE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05082

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Hagerstown RFD #3 d. STREET ADDRESS Sharpsburg Pike	
3. NAME OF DECEASED (Type or print) Mary Hetzer Downey		4. DATE OF DEATH April 30 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1885
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR 8 27 Months Days	
11. BIRTHPLACE (State or foreign country) Park Head Maryland		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Hetzer		14. MOTHER'S MAIDEN NAME Anna Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George B. Downey		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Ruptures, (Two) First Part Of Jejunum 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Generalized Peritonitis DUE TO Multiple Bony Fractures: Left Ilium Right (c) Patella	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 36 Hours	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Incollision with another car Sharpsburg Pike 1 mile South Of Hagerstown.	
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 4-28-62 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sharpsburg Pike		20f. (City or town) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. W. Ditto, Jr.		M.D. Dr. E. W. Ditto, Jr.	
NAME (Type) Dr. E. W. Ditto, Jr.		DATE SIGNED May 1, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2-62	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR Albert Leaf Williamsport, Md		24a. REC'D BY REGISTRAR MAY 3 '62	
		24b. REGISTRAR'S SIGNATURE Clarion S. Hume	

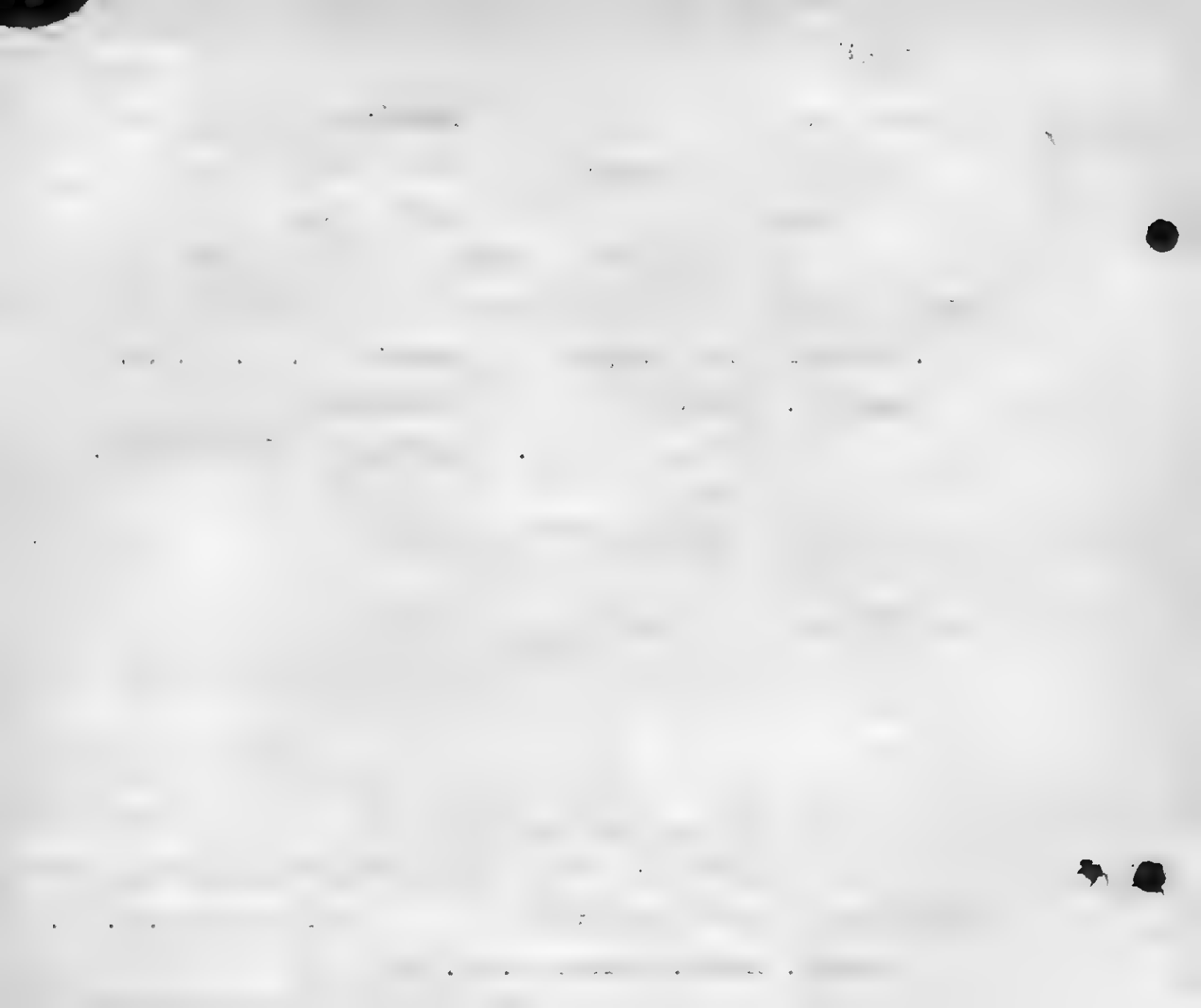
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05085
05083

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Marbern Road		2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS Marbern Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROY First Middle Last 4. DATE OF DEATH April 29 1962 Month Day Year		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH September 30, 1876 85 yrs. 9. AGE (in years last birthday) 85 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter 10b. KIND OF BUSINESS OR INDUSTRY self employed 11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Martin V. Easterday 15. WAS DECEASED EVER IN U.S. ARMED FORCES? no 16. SOCIAL SECURITY NO. 214-09-3826 17. INFORMANT Mrs. Margaret Ruth, Hagerstown, Md.		14. MOTHER'S MAIDEN NAME Susan Palmer Address Marbern Road		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 692.4 DUE TO Abscesses, multiple, right leg Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease, cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 months 2 months.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-24-62 to 4-28-62, death saw the deceased alive on 4-28-62 and that death occurred at 6:00 AM, from the causes and on the date stated above.		22a. SIGNATURE Robert F. Keadle 22c. PHYSICIAN'S NAME (Type) Robert F. Keadle 22d. ADDRESS 318 North Potomac Street, Hagerstown		22b. DATE SIGNED 4-30-62 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF May 1, 1962 23c. NAME OF CEMETERY OR CREMATORY Rest Haven 23d. LOCATION (City, town or county) Hagerstown Wash. Co. Md. (State)		24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle, Myersville, Md. ADDRESS 25a. REC'D BY REGISTRAR MAY 2 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1 (M)

DR LIE VAN

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05086
05084
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROHRERSVILLE</u> c. LENGTH OF STAY IN IT <u>75 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAIN ST.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROHRERSVILLE</u> d. STREET ADDRESS <u>MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>ALBERTA EASTON</u>		4. DATE OF DEATH <u>APRIL 4 - 1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 9, 1877</u>	
9. AGE (In years last birthday) <u>85 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PARK HALL WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN REEDER</u>		14. MOTHER'S MAIDEN NAME <u>MALINDA DICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. GROVER DORMAN HAGERSTOWN MD. R. 3</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs 1 wk</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unrecognized arteriosclerosis</u> +50.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of right hip</u> DUE TO (c)			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10, 1961</u> , to <u>4-4, 1962</u> , that (I) (we) last saw the deceased alive on <u>4-2, 1962</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>G. W. Luedan</u>		22b. DATE SIGNED <u>4/6/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Luedan</u>		22d. ADDRESS <u>Boonsboro, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 7-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROHRERSVILLE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>ROHRERSVILLE WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		25a. REC'D BY REGISTRAR <u>Boonsboro MD.</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>APR 11 '62</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05085

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

2 months

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

640 Summit Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution. Residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. STREET ADDRESS

640 Summit Ave

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☐

3. NAME OF DECEASED
(Type or print)

Lewis

Markell

Eberly

4. DATE OF DEATH

Month

April

Day

29

Year

19 62

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Feb. 16, 1962

9. AGE (In years last birthday)

2 yrs.

IF UNDER 1 YEAR

Months 2 Days 13

IF UNDER 24 HRS

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frank Eberly

14. MOTHER'S MAIDEN NAME

Norma Jean Neff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

Frank Eberly

Hagerstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

INTERSTITIAL PNEUMONIA

571.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Pulmonary congestion and edema

DUE TO

(c)

Gastro-enteritis, nonspecific

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

INTERVAL BETWEEN ONSET AND DEATH
Recent

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

E. W. DITTO, JR., M. D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Address (Street, city, town, or county)

4-30-62

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-30-62

22c. NAME OF CEMETERY OR CREMATORY

Rose Hill Cemetery

22d. LOCATION (City, town, or country)

Hagerstown, Md.

23. FUNERAL DIRECTOR

ADDRESS

Scott F. Minnich & Son Hagerstown, Md.

24a. REC'D BY REGISTRAR

DATE MAY 2 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

2-002509

05088

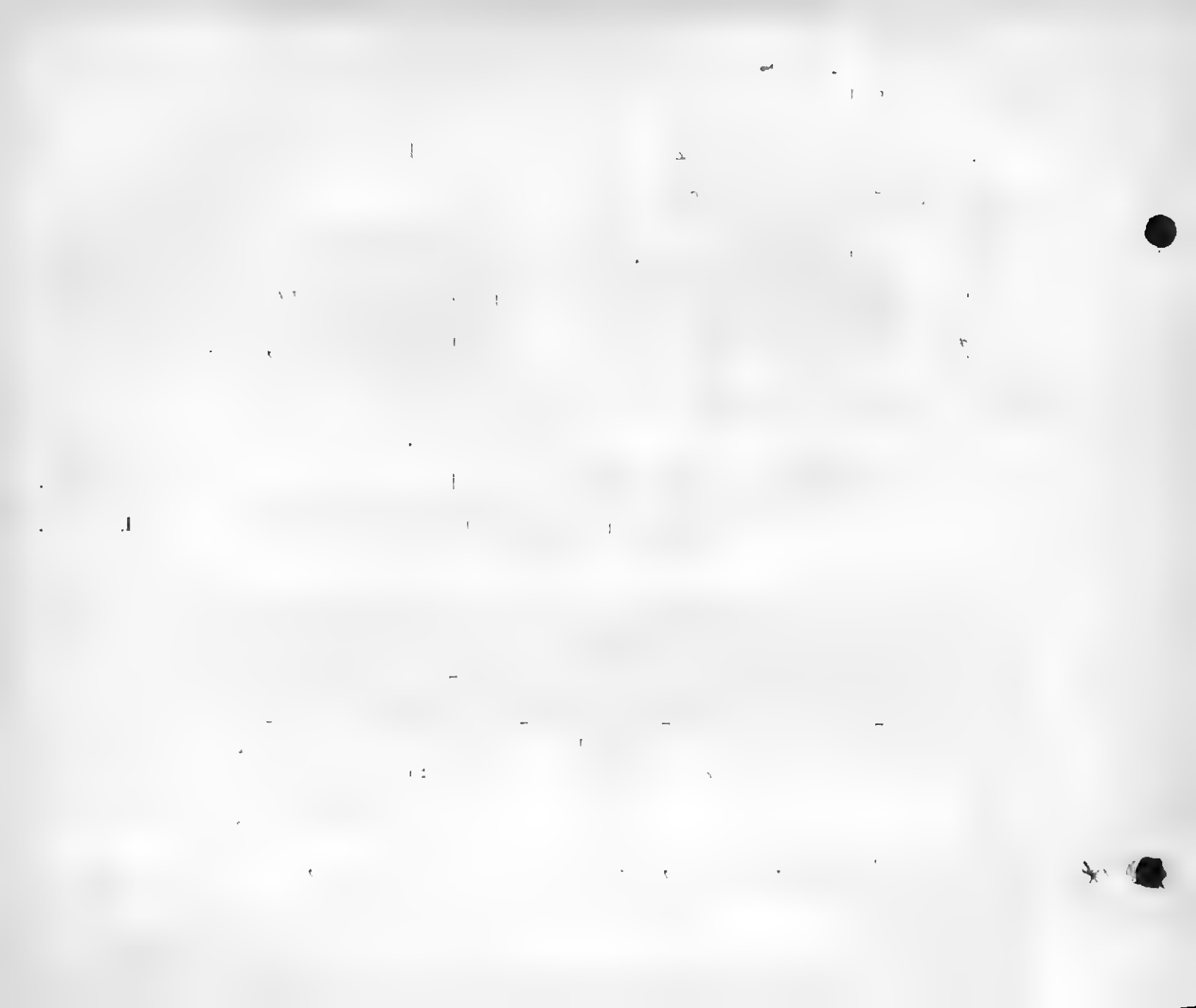
CERTIFICATE OF DEATH

Reg. Dist. No. 05086

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 10 X	
3. NAME OF DECEASED (Type or print) First RICHARD Middle E. Last FRANKLIN		4. DATE OF DEATH Month 4 Day 1 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1884
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ??		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) WASHINGTON COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles F. Downs		14. MOTHER'S MAIDEN NAME Anna R. Pierce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) (1) yes, give war or dates of service		16. SOCIAL SECURITY NO. HOWARD L. DOWNES	
17. INFORMANT HOWARD L. DOWNES		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-4-6 X DUE TO NEPHROSCHLEROSIS WITH UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCHLEROSIS (c) NO			INTERVAL BETWEEN ONSET AND DEATH 6 MO. 1 YR.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 4/1 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 832 POTOMAC AVE.	20f. (City or town) (County) (State) HAGERSTOWN, MARYLAND
21. I certify that I attended the deceased from 4/1 1962 , that I last saw the deceased alive on 4/1 1962 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jacob G. Warden, M.D.		DATE SIGNED 832 POTOMAC AVE.	
PHYSICIAN'S NAME (Type) JACOB G. WARDEN, M.D.		HAGERSTOWN, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/1/62	22c. NAME OF CEMETERY OR CREMATORY Grantsville Cem.	22d. LOCATION (City, town, or county) (State) Grantsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. P. Konhaus		ADDRESS Meersdale, Pa.	
24a. REC'D BY REGISTRAR APR 9 '62		24b. REGISTRAR'S SIGNATURE Arthur S. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05089 CERTIFICATE OF DEATH 05087

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holewood Church Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 21 East Antietam Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LAURA ELLEN FUNK		4. DATE OF DEATH April 24, 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1866 96
9. AGE (In years last birthday) 96		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	
11. BIRTHPLACE (County & State, or foreign country) St. James Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Solomon Funk		14. MOTHER'S MAIDEN NAME Catherine Rowland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Williamsport, Md. Homewood Church Home Records,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage (b) Cerebral Arteriosclerosis (c) General Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1960 to 4/24/62, that (I) last saw the deceased alive on 4/21/62, and that death occurred at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Louis S. Graff		22b. DATE SIGNED 7/5/62	
22c. PHYSICIAN'S NAME (Type) Louis S. GRAFF		22d. ADDRESS 119 E. Antietam Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/62	
23c. NAME OF CEMETERY OR CREMATORY Zion E&R Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Maryland		25a. REC'D BY REGISTRAR DATE APR 26 '62	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

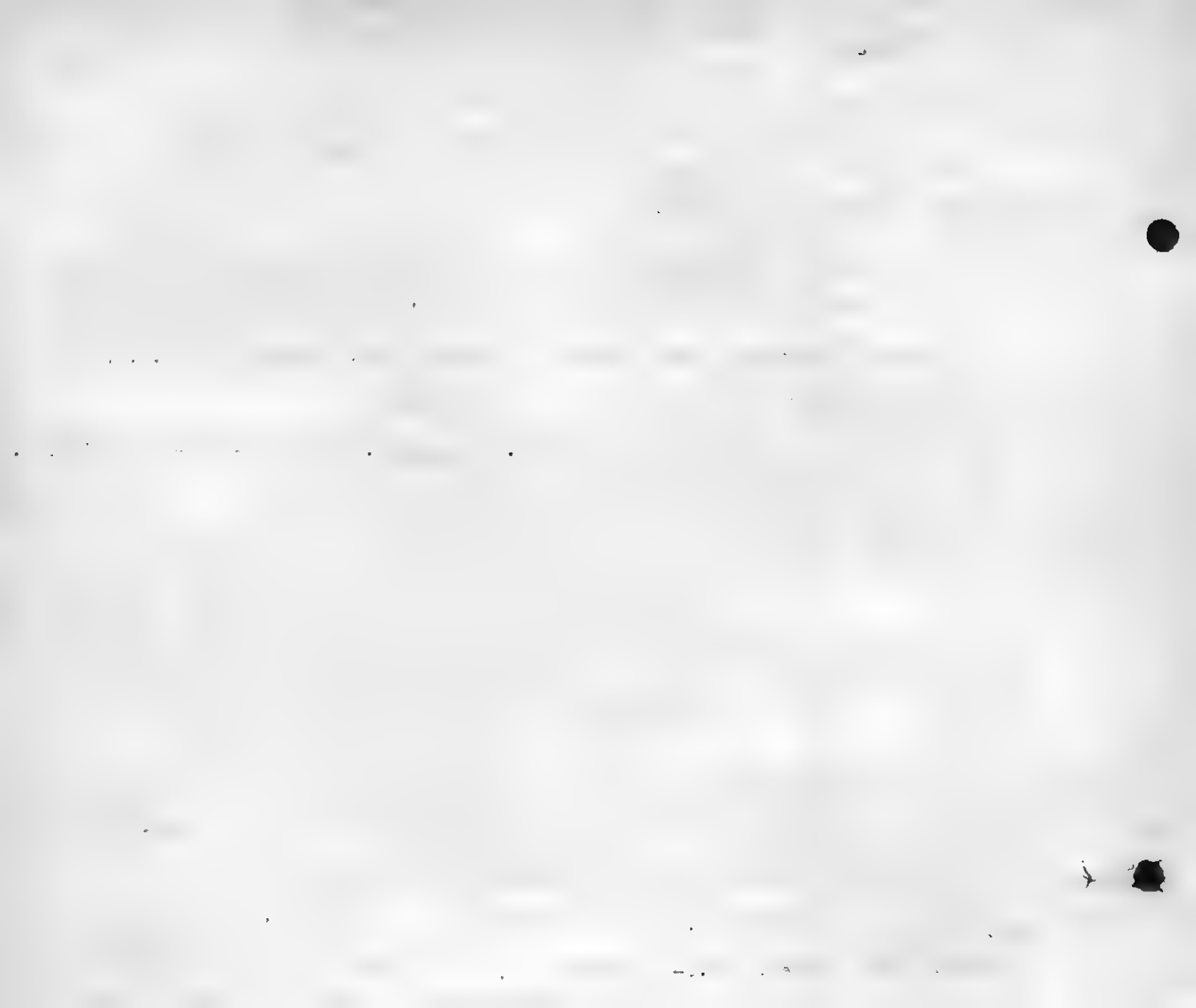
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05090

05088

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rock Point</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Richard Gooseberry</u> First Middle Last 4. DATE OF DEATH <u>4 20 1962</u> Month Day Year 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>January 1, 1904</u> 9. AGE (In years last birthday) <u>58</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oysterman (Waterman)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster Business</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Charles County, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Goosberry</u> 14. MOTHER'S MAIDEN NAME <u>Mary Butler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>213-16-2823</u> 17. INFORMANT <u>Mrs. Margaret E. Goosberry-Wife-Rock Point, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus</u> DUE TO Condition, if any, which gave rise to immediate cause (b) <u>150X</u> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>one year 4 months</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1962</u> to <u>April 20, 1962</u> that (I) <u>did not</u> last saw the deceased alive on <u>April 20, 1962</u> and that death occurred at <u>8:02 A.M.</u> from the causes and on the date stated above 22a. SIGNATURE <u>Young E. Chun</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>4/20/1962</u> 22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u> 22d. ADDRESS <u>1500 Penna Ave Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/24/1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Issue, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u> 25a. REC'D BY REGISTRAR <u>APR 25 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EAKLES MILL</u> c. LENGTH OF STAY IN 1b <u>10 YEARS</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EAKLES MILL - RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KEEDYSVILLE MD. R.I.</u>		d. STREET ADDRESS <u>KEEDYSVILLE MD. R.I.</u>	
3. NAME OF DECEASED (Type or print) <u>ADAM E. GREEN</u>		4. DATE OF DEATH <u>APRIL - 14 - 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 2 - 1892</u>
9. AGE (In years last birthday) <u>70 yrs.</u>		10. IF UNDER 1 YEAR <u>3</u> Months <u>12</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARM LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MYERSVILLE FRED. CO. MD U.S.A.</u>	
11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SAMUEL GREEN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET HOLMES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-18-1074</u>	
17. INFORMANT <u>MRS. LULA S. GREEN</u>		Address <u>KEEDYSVILLE MD. R.I.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>INTERMITTENT HEAD WITH</u> <u>DECOMPENSATION</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), (c): <u>1. HYPERTENSION</u> <u>2. DUE TO</u> <u>3. DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10:10</u>, 19 <u>61</u> , to <u>April 14</u>, 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 11</u>, 19 <u>62</u> , and that death occurred at <u>5:15</u> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>G.W. Ledan</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>G.W. Ledan</u>		22d. ADDRESS <u>Boonsboro</u>	
22e. DATE SIGNED <u>4/16/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 17, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MT. LENA WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>		ADDRESS <u>Boonsboro MD</u>	
25a. REC'D BY REGISTRAR <u>APR 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05092 CERTIFICATE OF DEATH 05090

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1019 Corbett St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jesse Franklin Greene</u> First Middle Last 4. DATE OF DEATH <u>April 1 1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 28, 1885</u> 9. AGE (In years last birthday) <u>76</u> yrs IF UNDER 1 YEAR Mon Hrs Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Hag. Gas Co.</u> 11. BIRTHPLACE (County & State, foreign country) <u>W. Va. Martinsburg, Berkly. Sp</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Martin Greene</u> 14. MOTHER'S MAIDEN NAME <u>Susan Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>317-09-2691A</u> 17. INFORMANT <u>Mrs. Virginia Corsi</u> Address <u>401 S. Potomac St.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular pneumonia, bil.</u> DUE TO (b) <u>cerebro-vascular accident</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>cerebro-vascular accident, old & hemiparesis</u> (b) <u>Hypertensive Cardio-vascular disease</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>9 days</u> <u>unknown</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>October 19, 1961</u> to <u>April 1, 1962</u> that (I) (we) last saw the deceased alive on <u>April 1, 1962</u> , and that death occurred at <u>12:30</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>		22b. DATE SIGNED <u>April 1, 1962</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/4/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>APR 3 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05093

05091

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County Hospital

3. NAME OF DECEASED (Type or print)

First

Middle

Last

JONATHAN

B.

GRONER

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Feb. 26, 1947

9. AGE (In years, if UNDER 1 YEAR, last birthday)

15 yrs.

Month

Day

Year

April 29, 1962

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel B. Groner

14. MOTHER'S MAIDEN NAME

Molly Wexler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

Molly W. Groner 413 Mansfield Rd., SSpg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

SHOCK DUE TO MASSIVE BRAIN DAMAGE
FRACTURED RTBS-FRACTURED LEFT ARM
& LEFT LEG.

INTERVAL BETWEEN
ONSET AND DEATH

24 HOURS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

PATIENT DIED ENROUTE BY AMBULANCE ON WAY TO CHILDREN'S HOSP.

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of form 100-10)

WASHINGTON, D.C.

20c. TIME OF INJURY

Hour XX: 5:00 p.m.

Month, Day, Year

4-28

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)

RT. #40, GRANTSVILLE, MD.

20f. CITY OR TOWN

HAGERSTOWN WASH. MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type)

DR. E.W. DITTO, JR.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

May 1, 1962

22c. NAME OF CEMETERY OR CREMATORY

National Memorial Park

22d. LOCATION (City, town, or country)

Falls Church, Va.

(State)

23. FUNERAL DIRECTOR

Geeshing Funeral Home

ADDRESS

4217 9th Street N.W.

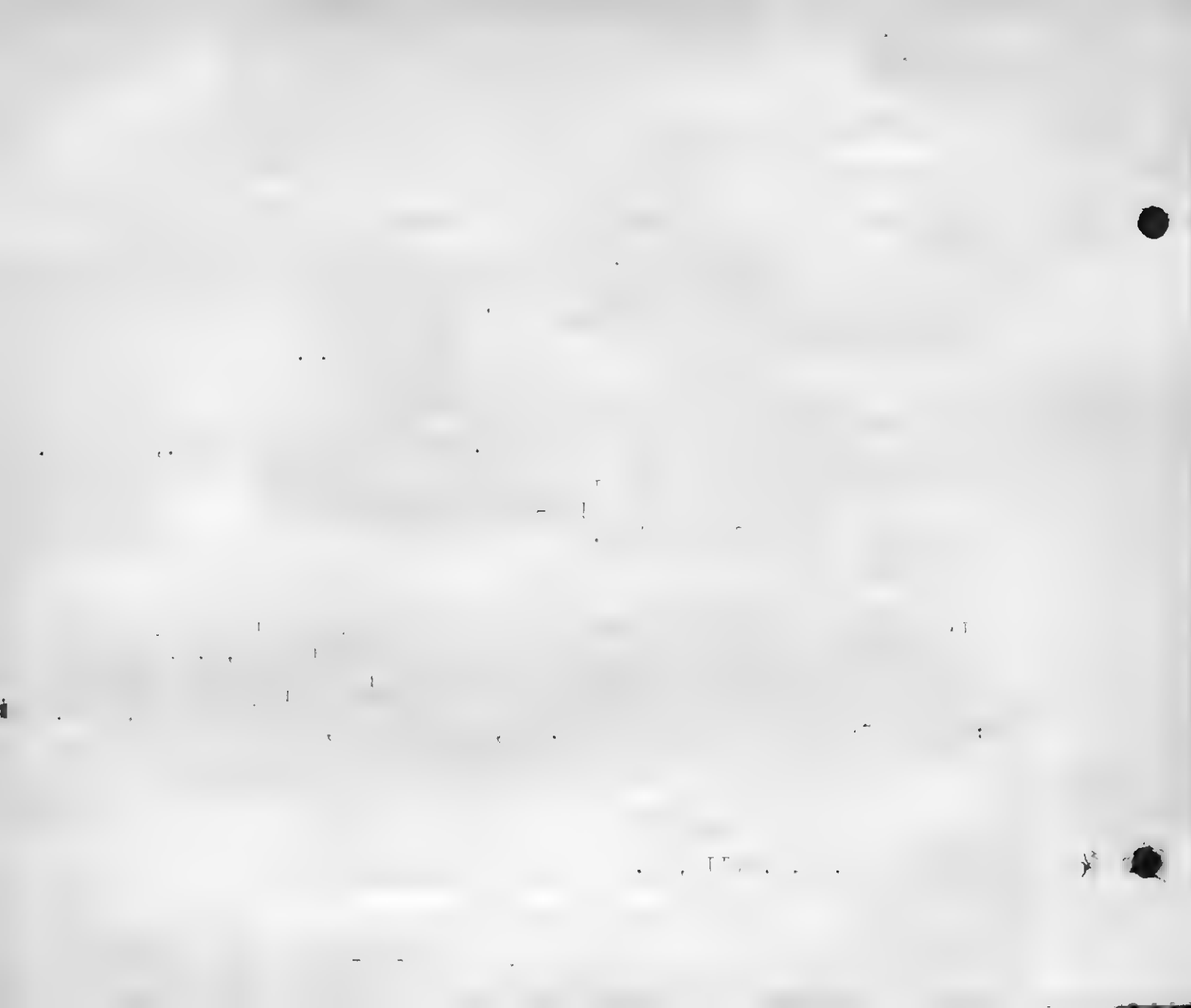
24a. REC'D BY REGISTRAR

DATE 4-29-62

24b. REGISTRAR'S SIGNATURE

MAY 3 '62

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1-2
MARYLAND STATE DEPARTMENT OF HEALTH

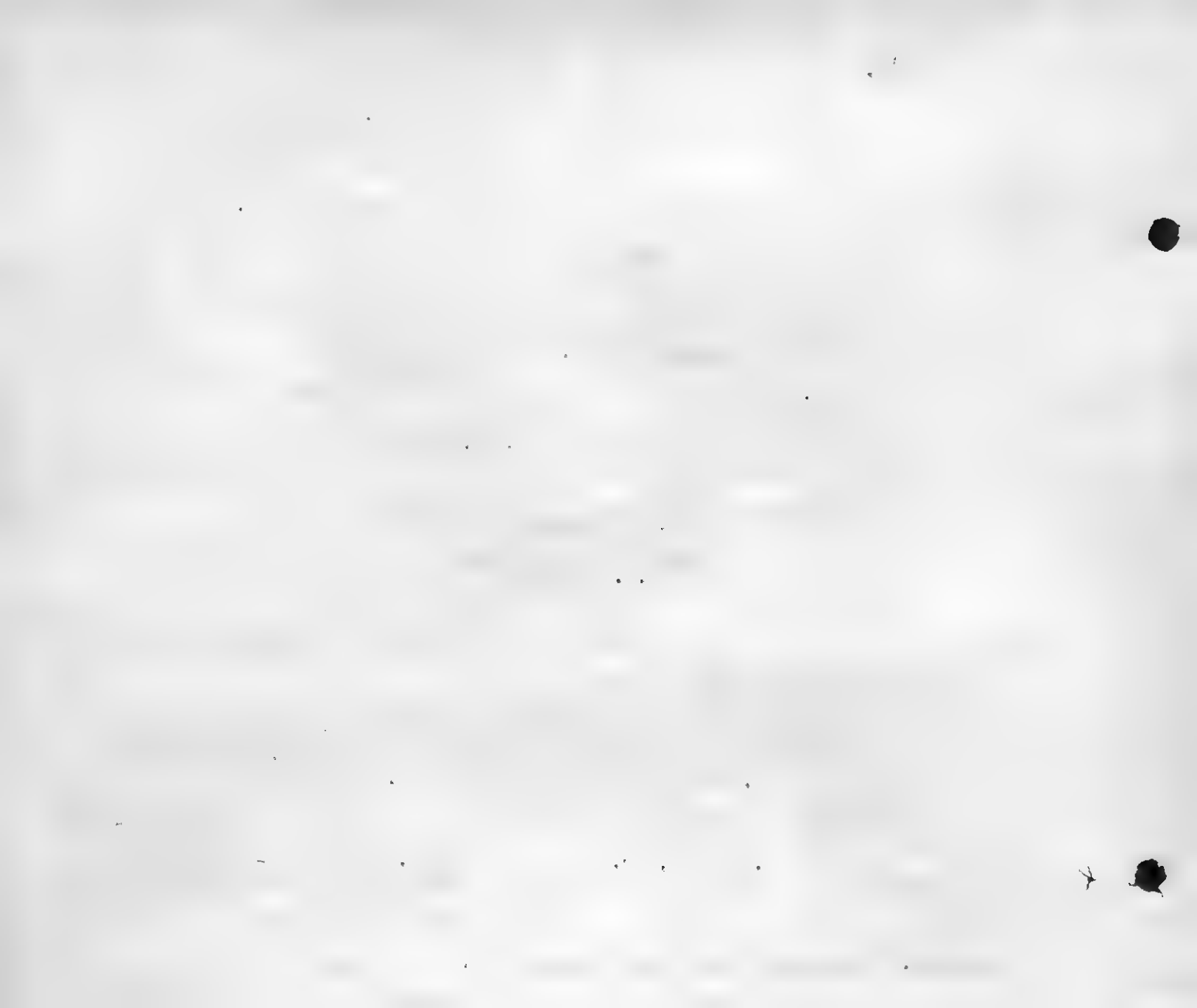
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05094

CERTIFICATE OF DEATH

05092

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 26 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1241 Potomac Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anthea Ruth Hankey First Middle Last 4. DATE OF DEATH April 14, 1962 Month Day Year		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 10, 1917 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years, last birthday) 44 yrs If UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) assembler 10b. KIND OF BUSINESS OR INDUSTRY aircraft mfg. 11. BIRTHPLACE (County & State, or foreign country) Somerset, Penna. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Ira R. Barron 14. MOTHER'S MAIDEN NAME Anna Baltzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. 214-09-8783 17. INFORMANT Wm. L. Hankey, Jr., Hagerstown, Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardiac Hypertension DUE TO R. L.L. Pneumonia	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY Month, Day, Year none 19 Hour a.m. p.m. 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none 20e. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from July 1961 , to Apr. 14, 1962 , that (I) (we) last saw the deceased alive on Apr. 14, 1962 , and that death occurred at P.M. from the causes and on the date stated above.	
22a. SIGNATURE Harold R. Tritch Jr 22c. PHYSICIAN'S NAME (Type) Harold R. Tritch, Jr. MD		22b. DATE SIGNED 4-16-62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 302 N. Potomac St-Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 4-17-62 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md. ADDRESS 25a. REC'D BY REGISTRAR APR 18 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05095

05093

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Sharpsburg c. LENGTH OF STAY IN b. 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sharpsburg On RFD #34		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sharpsburg d. STREET ADDRESS Sharpsburg RFD #1	
3. NAME OF DECEASED (Type or print) Donald Alvin Helman Jr.		4. DATE OF DEATH April 8 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8 1942
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		9. AGE (In years last birthday) 19 yrs. IF UNDER 1 YEAR: Months 4 Days 10 Hours Min. 	
10b. KIND OF BUSINESS OR INDUSTRY Hilling Station		11. BIRTHPLACE (State or foreign country) Mercersburg Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Donald Alvin Helman Sr.	
14. MOTHER'S MAIDEN NAME Anna Virginia Yeager		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. 215-42-3778		17. INFORMANT Mr. J. Edgar Churchey Address Sharpsburg RFD #1 Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull 819 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Struck abutment of underpass R# 34, 2 mile West of Sharpsburg, Md.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 4-8- 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State R # 34		20f. (City or town) Sharpsburg, Washington, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11-62	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or country) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR Albert L. Lee Williamsport, Md. ADDRESS		24a. REC'D BY REGISTRAR APR 12 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		DATE	

DATE SIGNED

4-9-62

requires that the death certificate be ex-
amined by the attending physician and
signed by the physician and
the funeral home.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05096

05094

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>3 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>22 SOUTH POTOMAC ST.</u>	
3. NAME OF DECEASED (Type or print) <u>GRACE-LINNIE - HELSER</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>MARCH 11, 1901</u> 9. AGE (In years last birthday) <u>61</u> yrs. <u>1</u> month <u>16</u> days		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DEVON HOTEL</u> 11. BIRTHPLACE (County & State, or foreign country) <u>DAK GROVE PENNA. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM HELSER</u> 14. MOTHER'S MAIDEN NAME <u>ADDIE DALE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> 16. SOCIAL SECURITY NO. <u>220-16-3741</u> 17. INFORMANT <u>MRS. LEROY HARTRANFT</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>3/2/62</u> (c), stating the underlying cause last. DUE TO <u>3/2/62</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/62</u> to <u>3/2/62</u> , that (I) (we) last saw the deceased alive on <u>3/1/62</u> , and that death occurred at <u>3/2/62</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>JTB</u>		22b. DATE <u>3/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JTB</u>		22d. ADDRESS <u>HAGERSTOWN MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 1, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>REEDSVILLE WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Best</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kane</u>	
25b. REGISTRAR'S SIGNATURE <u>Boonsboro MD.</u>		DATE <u>MAY 4 '62</u>	

MEDICAL CERTIFICATION

This certificate is detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. JACK BEACHLEY 226 W. WASH. ST.

(I)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05097

05095

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>509 Beverly Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Linda Sue Hemphill</u> First Middle Last 4. DATE OF DEATH <u>April 14 1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 3, 1961</u> 9. AGE (In years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George W. Hemphill</u> 14. MOTHER'S MAIDEN NAME <u>Eather G. Sheasley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr. Geo. W. Hemphill</u> Address <u>509 Beverly Lane Hagerstown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Distention</u> 75() } DUE TO (b) <u>Post surgical correction of malrotation of intestine</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>marked adhesions</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> 19 <u>62</u> to <u>4/14</u> 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>1/14</u> 19 <u>62</u> , and that death occurred at <u>1:45</u> AM, from the causes and on the date stated above;	
22a. SIGNATURE <u>Richard A. Young</u> M.D. 22b. DATE SIGNED <u>4/16/62</u> 22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/16/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> ADDRESS <u>Hagerstown, Md.</u> 25a. REC'D BY REGISTRAR DATE <u>APR 17 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u>	

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05098

05096

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d STREET ADDRESS <u>148 N. Carlisle St</u>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Edith</u> Last <u>Henson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 28, 1887</u>
9. AGE (In years lost birthday) <u>74</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Henry Lum</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Atherton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr Kenneth N Henson</u>		Address <u>Greencastle, Pa</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <u>422.1</u> DUE TO <u>arteriosclerotic Cardio-vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>disease</u> (b) <u>18 days</u> (c) <u>15 yrs.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>4/12</u> to <u>4/30</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/30/62</u> and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.			
22a SIGNATURE <u>W.C. Brewer, M.D.</u>		22b DATE SIGNED <u>5/30/62</u>	
22c PHYSICIAN'S NAME (Type) <u>W.C. Brewer, M.D.</u>		22d ADDRESS <u>Greencastle, Pa</u>	
23a BURIAL, CREMAT. ON, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5-3-1962</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Zimmerman</u>		25. REC'D BY REGISTRAR <u>Arthur S. Kiana</u>	
ADDRESS <u>Greencastle, Pa</u>		DATE <u>MAY 7 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

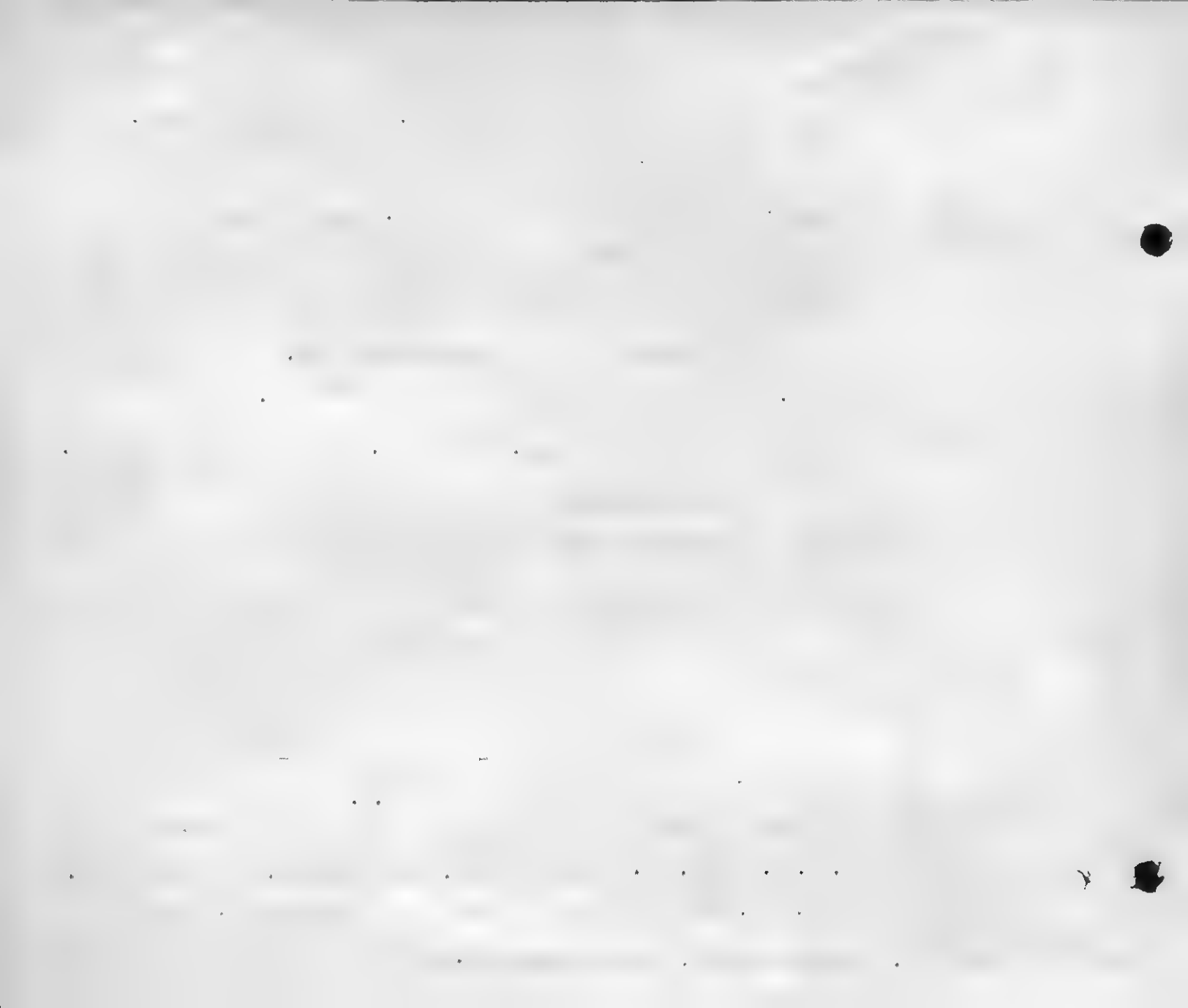
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05099

05097

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in life life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institutions Res dence before adm ssion) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 551 W. Howard St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Waldo Emerson Hill		4. DATE OF DEATH April 7, 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1894
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) car inspector		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE County & State, or foreign country Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David E. Hill		14. MOTHER'S MAIDEN NAME Ida F. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO WW I	
17. INFORMANT Mrs. Beulah M. Hill, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Hypertensive Cardio Vascular Disease DUE TO (c) 15 months. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 months.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 3-1-1962 to 4-7-1962 that (I) (we) last saw the deceased alive on 4-7-1962 , and that death occurred at 6:30 P.M. from the causes and on the date stated above			
22a. SIGNATURE Dr. E. W. Ditto, Jr.		22b. DATE SIGNED 4-9-62	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Apr. 10, 62	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24b. ADDRESS	
25a. REC'D BY REGISTRAR APR 11 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Minnich	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05098

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO
c. LENGTH OF STAY IN b. 1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ENROUTE TO HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - EAKLES MILL
d. STREET ADDRESS KEEDYSVILLE MD. R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) JESSIE LEATHER CLAY HOLMES
4. DATE OF DEATH APRIL - 6 - 1962
5. SEX MALIE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH APRIL - 30 - 1889
9. AGE (In years last birthday) 72 yrs. 11 months 6 days hours min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYEE B & O R.R. CO
11. BIRTHPLACE (State or foreign country) NR. KEEDYSVILLE WASH. CO. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME NELSON HOLMES
14. MOTHER'S MAIDEN NAME SUSAN SMITH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO
16. SOCIAL SECURITY NO.
17. INFORMANT MRS. MARY DITTO Address HAGERSTOWN MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crushed Chest
DUE TO 8.16X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. Car he was driving ran into rear of car he was following.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 8 - 4 - 6 - 19 62
20d. INJURY OCCURRED While ☒ at work Not While ☐ at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B# 40 A. Boonsboro, Washington, Md.
20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 4-7-62
Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF APRIL - 9 - 1962
22c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY
22d. LOCATION (City, town, or country) (State) LOCUST GROVE WASH. CO. MD
23. FUNERAL DIRECTOR John H. Best Address BOONSBORO MD
24a. REC'D BY REGISTRAR DATE APR 11 '62
24b. REGISTRAR'S SIGNATURE Carroll S. Thomas

MEDICAL CERTIFICATION

M

05101

CERTIFICATE OF DEATH

Reg. Dist. No. 05099

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MICHAEL</u> First <u>L.</u> Middle <u>HORSH</u> Last		4. DATE OF DEATH <u>4/25</u> Month <u>4</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landis Tool Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Opton, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Horsh</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Sheeley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>204-03-5672</u>	
17. INFORMANT <u>Estelle C. Horsh</u> Address <u>RD 1 Greencastle, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis (arteriosclerosis)</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Myocardial infarction syndrome</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary thromboembolism</u> INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July, 1955</u> to <u>Apr 25, 1962</u> that I last saw the deceased alive on <u>Apr 25, 1962</u> and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u> DATE SIGNED <u>Apr 30 '62</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Greencastle, Pa.</u>			
PHYSICIAN'S NAME (Type) <u>A. C. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/28/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Opton Brethren Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Opton, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Nimmich</u> ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>APR 30 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05102

CERTIFICATE OF DEATH

05100

1. PLACE OF DEATH
a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b. 1 Day

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1707 Sherman Ave e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY HUFF 4. DATE OF DEATH Month Day Year April 6 1962 19

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH March 16 1883 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman - Retired 10b. KIND OF BUSINESS OR INDUSTRY C&P Tel. Co 11. BIRTHPLACE (County & State or foreign country) W. Va. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Noah Huff 14. MOTHER'S MAIDEN NAME Ella Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 212-05-0839 17. INFORMANT Address Mrs Ola D. Huff 1707 Sherman Ave Hagerstown Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cor pulmonale
DUE TO (b) Emphysema
DUE TO (c) anticoagulant & nephrosclerosis
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) anticoagulant & nephrosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/7/ 1962 to 4/6 1962 that (I) (we) last saw the deceased alive on 4/6 1962, and that death occurred at 4/6 M, from the causes and on the date stated above.

22a. SIGNATURE Howard N. Weeks M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 4/6/62

22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. 22d. ADDRESS 136 N. Potomac Street

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/9/62 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md. ADDRESS 136 N. Potomac Street 25a. REC'D BY REGISTRAR APR 10 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 05101

05103

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) o STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mercersburg, Pa.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D.1</u>		d. STREET ADDRESS <u>R.D.1</u>	
3. NAME OF DECEASED (Type or print) <u>William H. Hunsberger</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>13</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/8/1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGION</u>	
11. BIRTH PLACE (State or foreign country) <u>Washington Co., Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID HUNSBERGER</u>		14. MOTHER'S MARDEN NAME <u>JANE RINGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>C.W. HUNSBERGER, MERCERSBURG, PA., R.2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis</u> DUE TO <u>1200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 17, 1955</u> to <u>APR 13, 1962</u> that I last saw the deceased alive on <u>APR 10, 1962</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>4/13/62</u>			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		DATE SIGNED <u>4/13/62</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>4/15/62</u>	<u>BROADFORDING Cem.</u>	<u>Washington Co., Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Huns</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO INITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

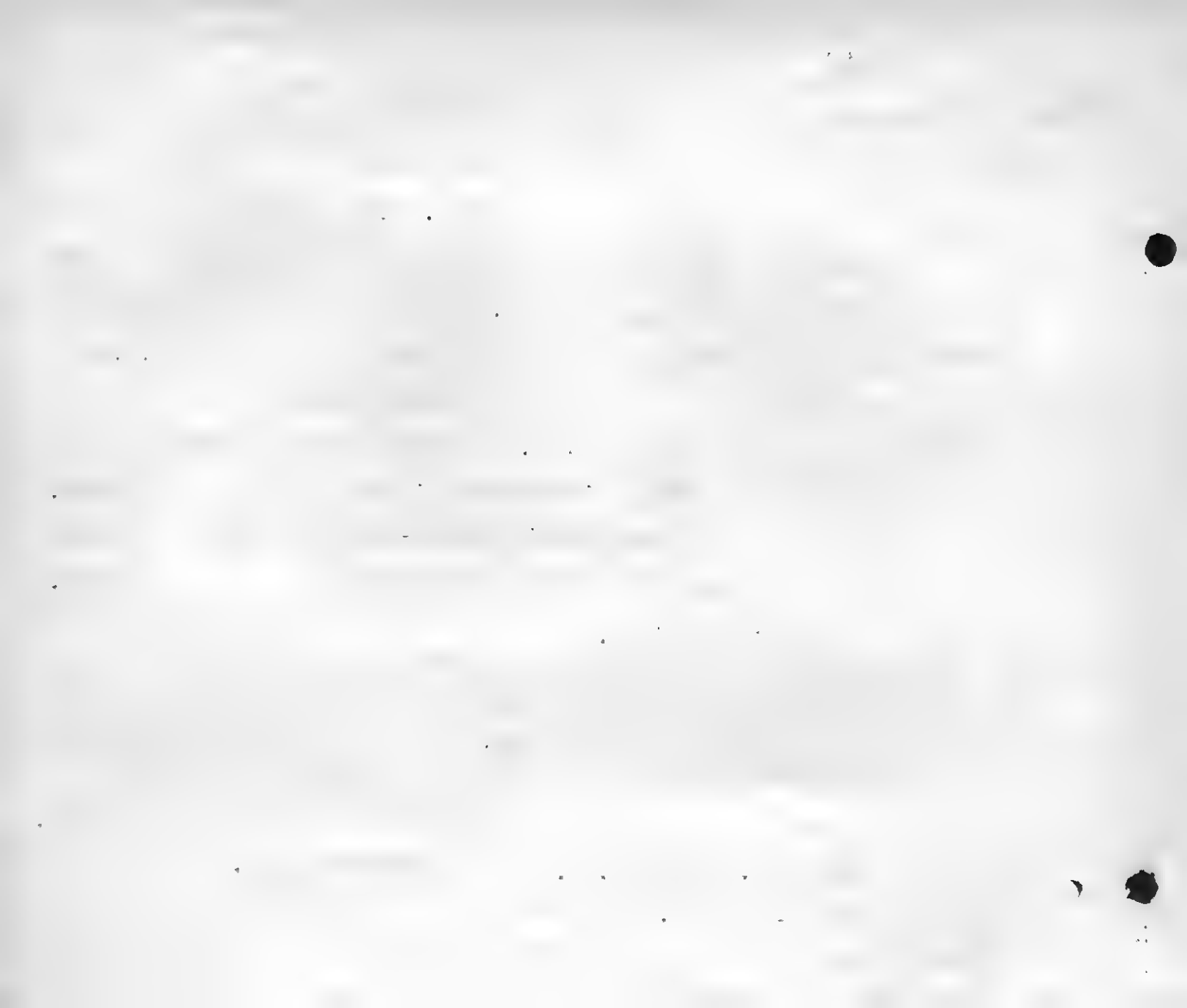
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05104

05102

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>138 W. Main Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Lucinda</u> Last <u>Hutson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 26 1882</u> 9. AGE (in years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>3</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Pierce</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Mae Hebb Sharpsburg Maryland</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Congestive heart failure</u> <u>4 years</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last } (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>Arteriolar-nephro-sclerosis</u> 1 year.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes mellitus.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>62</u> , to <u>May 1</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>May 1</u> , 19 <u>62</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Walter H. Shealy</u>		22b. DATE SIGNED <u>May 2, 1962.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>		22d. ADDRESS <u>Sharpsburg, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 3-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 4 '62</u>	
ADDRESS <u></u>		25b. REGISTRAR'S SIGNATURE <u>Clarence S. Kneass</u>	



TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05105
05103
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>9 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>121 East Franklin Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>121 East Franklin Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY DELOSIER JACKSON</u>		4. DATE OF DEATH <u>April 17, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 10, 1882</u>
9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>20</u> Hours <u>4</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James K. Delosier</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Clevidence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-34-3891</u>	
17. INFORMANT <u>Mrs. Bertha M. Bergum</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension and Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>after birth</u> (a), stating the underlying cause last. (c) <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1961</u> to <u>April 17, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 10, 1962</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Colfman</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. DATE <u>4/10/62</u>	

1 (M)
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05106
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05104

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clubhouse 3mi. South Of Sharpsburg</u> c. LENGTH OF STAY IN 1b <u>State R # 34</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>27 Wayside Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ralph Frederick Keplinger Sr.</u>		4. DATE OF DEATH <u>April 30 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe repair shop Wash. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>John Keplinger</u>		14. MOTHER'S MAIDEN NAME <u>Anna Mull</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W. W. I</u>		16. SOCIAL SECURITY NO. <u>214-09-5418</u>	
17. INFORMANT <u>Mrs. Grace Keplinger</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation Carbon Monoxide</u> 911 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Connected hose from exhaust pipe inserted into closed car.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11 4-30- 19 62</u> Hour a.m. <u> </u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R # 34</u>		20f. (City or town) <u>Sharpsburg, Washington, Md.</u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-3-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or country) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR <u>Scott F. Minnich & Son Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 4 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>			

MEDICAL CERTIFICATION

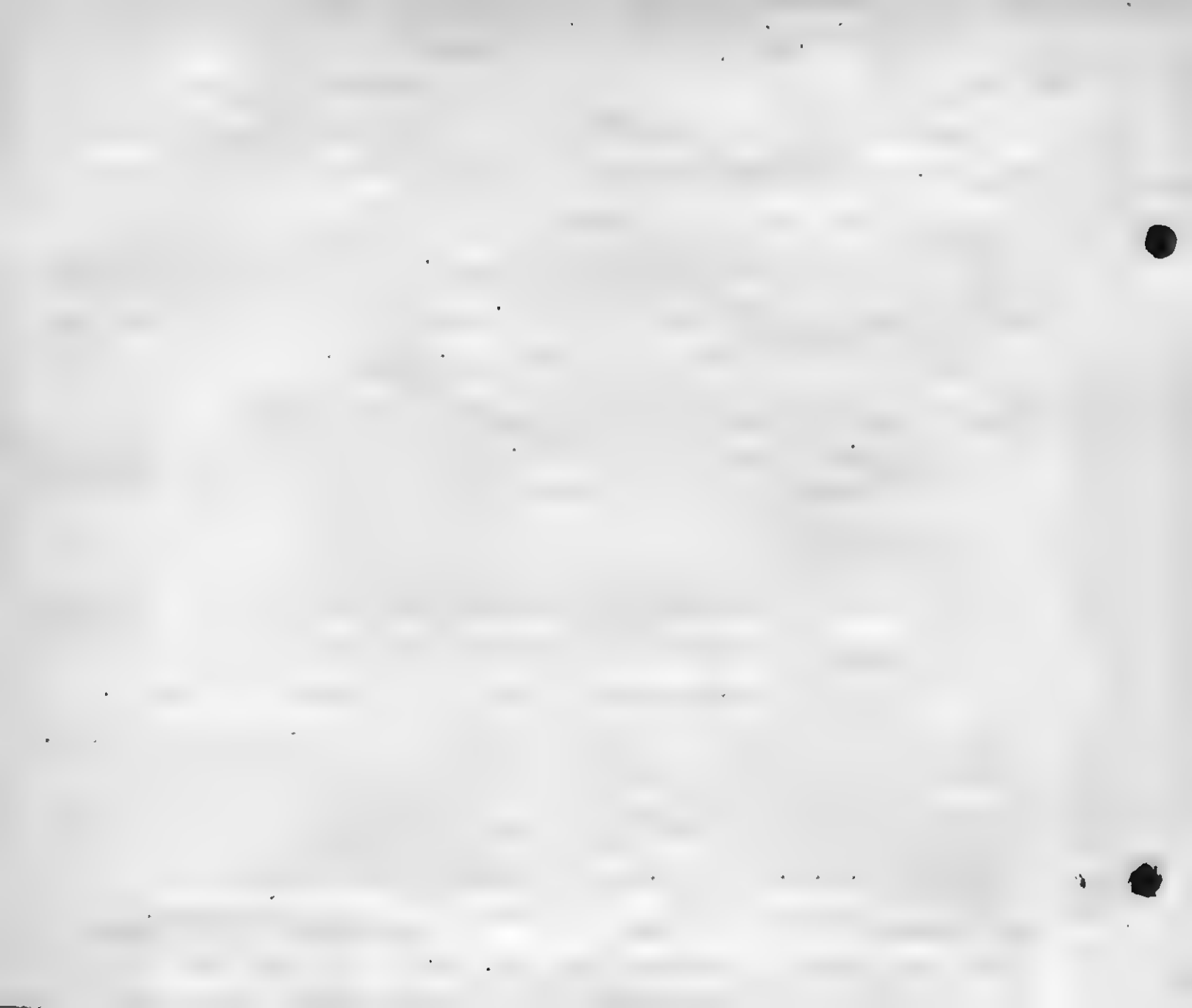
SIGNATURE
EXAMINER'S NAME (Type)

A. W. Ditto, Jr.
Dr. E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or country)

DATE SIGNED

May 2, 1962



CERTIFICATE OF DEATH

05107

05105

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HAGERSTOWN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			
c. LENGTH OF STAY IN 1b <u>LIFE</u>				d. STREET ADDRESS <u>1309 S. POTOMAC ST.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospite., give street address) <u>WASHINGTON COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TODD</u> <u>DWAYNE</u> <u>KRESSLIIG</u>				4. DATE OF DEATH Month Day Year <u>APRIL</u> <u>12</u> <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/1905</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HOWARD LOVELL KRESSLIIG</u>				14. MOTHER'S MAIDEN NAME <u>ANNA DAYAUDE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MR. DONALD L. KRESSLIIG</u>				Address <u>HAGERSTOWN, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrops Fetalis</u> DUE TO (b) <u>7700</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVA. BETWEEN ONSET AND DEATH <u>2 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>none</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <u>Apr. 12</u>, 1962, to <u>Apr. 12</u>, 1962, that (I) (we) last saw the deceased alive on... <u>Apr. 12</u> 19 <u>62</u> , and that death occurred at <u>10AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harold R. Tritch, Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>Harold R. Tritch, Jr. MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>302 N. Potomac St Hagerstown, Md</u>		22b. DATE SIGNED <u>4-13-62</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/13/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR L. I.</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Normant, Hagerstown, Md.</u>				25a. REG'D BY REGISTRAR DATE <u>APR 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 months after the date of death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 months after the date of death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05108 CERTIFICATE OF DEATH 05106

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in lb <u>6 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>		d. STREET ADDRESS <u>227 Springdale Street</u>	
3. NAME OF DECEASED (Type or print) <u>Clara A. KIMMELL</u>		4. DATE OF DEATH <u>4 4 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Garrett, Somerset Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Kaiser Kimmel</u>		14. MOTHER'S MAIDEN NAME <u>Enna Wooley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. Mary Vaillant</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA BILATERAL</u> DUE TO (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>ACUTE & CHRONIC PYELONEPHRITIS - DIABETES MELLITUS</u>	
19. WAS AUTOPSY PERFORMED? <u>YES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-DAYS</u> <u>9-MONTHS</u> <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 16, 1961</u> to <u>April 4, 1962</u> that (I) <u>(was)</u> last saw the deceased alive on <u>April 4, 1962</u> and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Antonio U. Pallagosi</u> M.D.	
22b. DATE SIGNED <u>4-5-62</u>		22c. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGOSI</u>		22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Toledo Memorial Cemetery, Sylvania, Ohio</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>APR 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>Hagerstown, Maryland</u>	



1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 443 N. Prospect St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Douglas Lee Kunkle		F. First Douglas		Middle Lee		Last Kunkle	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 4, 1942	
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 19 Days 19		IF UNDER 24 HRS. Hours 19 Min. 19		4. DATE OF DEATH Month April Day 2 Year 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack U. Kunkle		14. MOTHER'S M.A.D.E.N NAME Lillian J. Walden					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. J. U. Kunkle 443 N. Prospect St. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Hemorrhage 12-31-62 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Lacerations (c) Gastric Ulcer With Hemorrhage (d) Pneumonitis		INTERVAL BETWEEN ONSET AND DEATH 3 months 3 months		Recent			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) In Auto accident on R# 40 A, 5 mi. East of Hagerstown, Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) In Auto accident on R# 40 A, 5 mi. East of Hagerstown, Md.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12-31-1962		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 A.		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-3-62			
ACTUAL SIGNATURE A. E. Ditto		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E. H. Ditto, Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/62		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR Rest Haven Funeral Chapel		Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 5 '62		24b. REGISTRAR'S SIGNATURE Clara S. Kunkle	

CERTIFICATE OF DEATH

051110

05108

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u></p> <p>c. LENGTH OF STAY IN TB <u>ONE MONTH</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>214 NORTH POTOMAC ST.</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)</p> <p>a. STATE <u>DISTRICT OF COLUMBIA</u></p> <p>b. COUNTY <u>WASHINGTON</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2123 EYE ST. N.W.</u></p> <p>d. STREET ADDRESS <u>2123 EYE ST. N.W.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>BLANCHIE B. LAMAR</u></p> <p>5. SEX <u>FEMALE</u></p> <p>6. COLOR OR RACE <u>WHITE</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>JUNE-30-1895</u></p> <p>9. AGE (In years last birthday) <u>66</u> yrs. <u>9</u> Months <u>20</u> Days <u>1</u> Hours <u>1</u> Min.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. SENATOR</u></p> <p>11. BIRTHPLACE (County & State, or foreign country) <u>BOONSBORO WASH. CO. MD. USA</u></p> <p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	
<p>13. FATHER'S NAME <u>ROBERT F. LAMAR</u></p> <p>14. MOTHER'S MAIDEN NAME <u>NELLIE EAKLE</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)</p> <p>16. SOCIAL SECURITY NO. <u>577-56-9651</u></p> <p>17. INFORMANT <u>MRS. ROSS BOWARD</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u></p> <p>Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u></p> <p>(a), stating the underlying cause last. (c) <u>UNKNOWN</u></p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>		<p>20c. TIME OF INJURY Month, Day, Year <u>19</u></p> <p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>26 March</u>, 19<u>62</u>, to <u>20 April</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>20 April</u>, 19<u>62</u>, and that death occurred at <u>5 PM</u>, from the causes and on the date stated above</p>			
<p>22a. SIGNATURE <u>[Signature]</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>D. G. [Signature]</u></p>		<p>22b. DATE SIGNED <u>20 April 1962</u></p> <p>22d. ADDRESS <u>Boonsboro MD.</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p> <p>23b. DATE THEREOF <u>APRIL 23, 1962</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u></p> <p>23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD.</u></p>		<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. East</u></p> <p>25a. REC'D BY REGISTRAR <u>APR 25 '62</u></p> <p>25b. REGISTRAR'S SIGNATURE <u>Arthur L. Knecht</u></p>	

SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

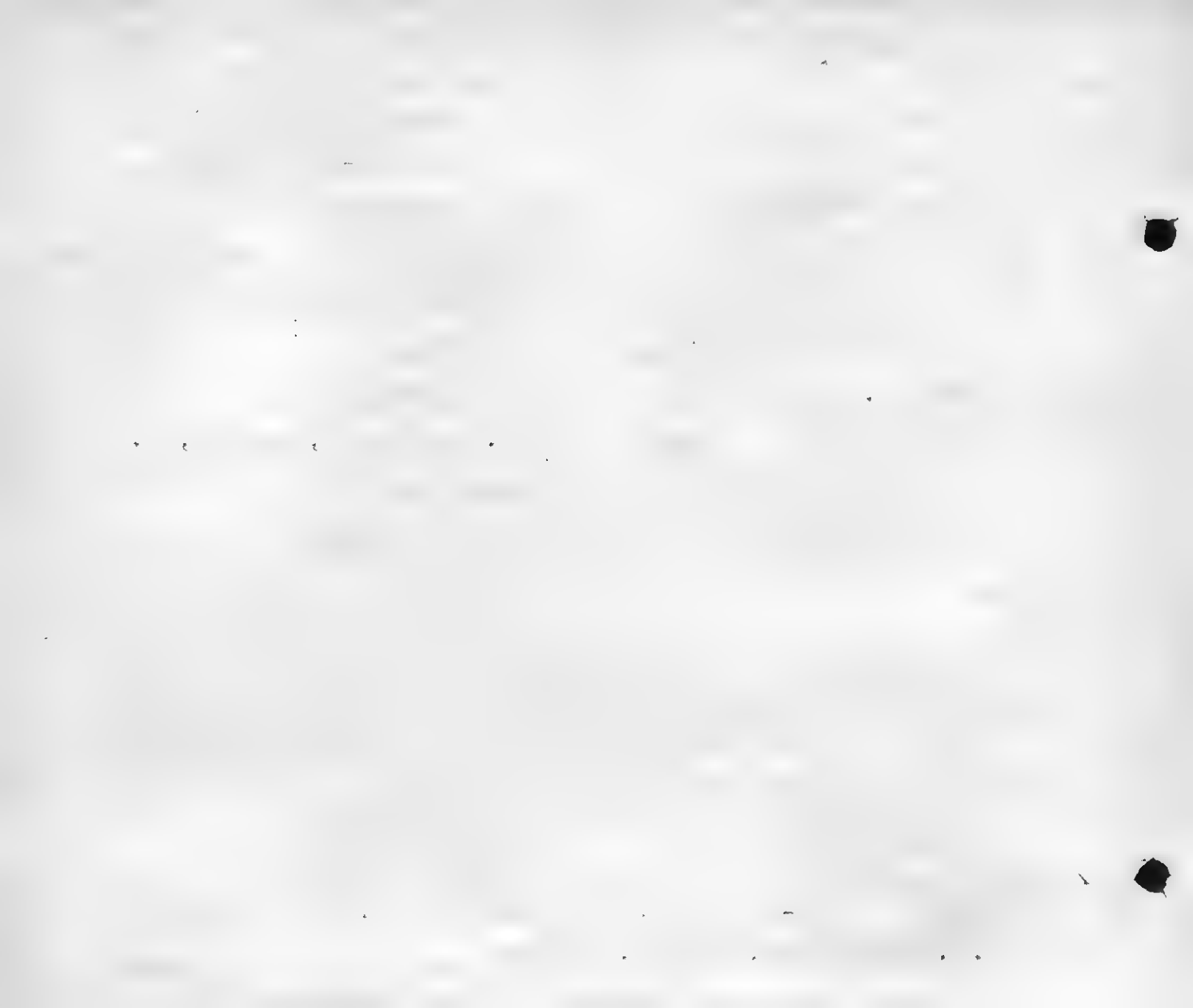
05111

05109

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural - Route 6</u> d. STREET ADDRESS <u>Bartonsville</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bertha</u> MAY Lare 4. DATE OF DEATH <u>April 12, 1962</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>16 Dec 1879</u> 9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-work</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Charles M. Lare</u> 14. MOTHER'S MAIDEN NAME <u>Annie Barnes</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Roy E. Lare, Route 1, Knoxville, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Fractured Right Hip</u> (c), stating the underlying cause last. } DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs 1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> , 19 <u>62</u> , to <u>April 12</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 11</u> , 19 <u>62</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>G. W. Lare</u> 22c. PHYSICIAN'S NAME (Type) <u>G. W. Lare</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Boonsboro</u> 22b. DATE SIGNED <u>4/12/62</u> <u>md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town or county) <u>Frederick, Maryland</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>				25a. REC'D BY REGISTRAR <u>APR 14 1962</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE HEALTH DEPT. M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05112
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05110
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 15 <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>62 MADISON AVENUE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>62 MADISON AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES FINDLAY LITTLE</u>	4. DATE OF DEATH <u>APRIL 15 1962</u>	5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 17 1896</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER COAL COMPANY</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON MARYLAND</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES A LITTLE</u>	14. MOTHER'S MAIDEN NAME <u>SOPHIA FINDLAY</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WW 1</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>MRS. NANCY KNOWLES NEW YORK CITY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Descending Colon</u> DUE TO <u>1-3-2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Diastatic Perforation Of Ascending Colon With</u> DUE TO <u>Acute Generalized Peritonitis.</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>4-20-62</u> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>215 W WASHINGTON ST</u> Address (Street, city, town, or county) <u>HAGERSTOWN MARYLAND</u>			
ACTUAL SIGNATURE <u>E.W. DITTO JR.</u> EXAMINER'S NAME (Type) <u>E.W. DITTO JR. M. D.</u>	22a. BURLIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-18-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEMETERY</u> ADDRESS <u>WILLIAMSPORT MARYLAND</u>
23. FUNERAL DIRECTOR <u>Super-Houzer Funeral Home</u>	24a. REC'D BY REGISTRAR <u>APR 23 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>	



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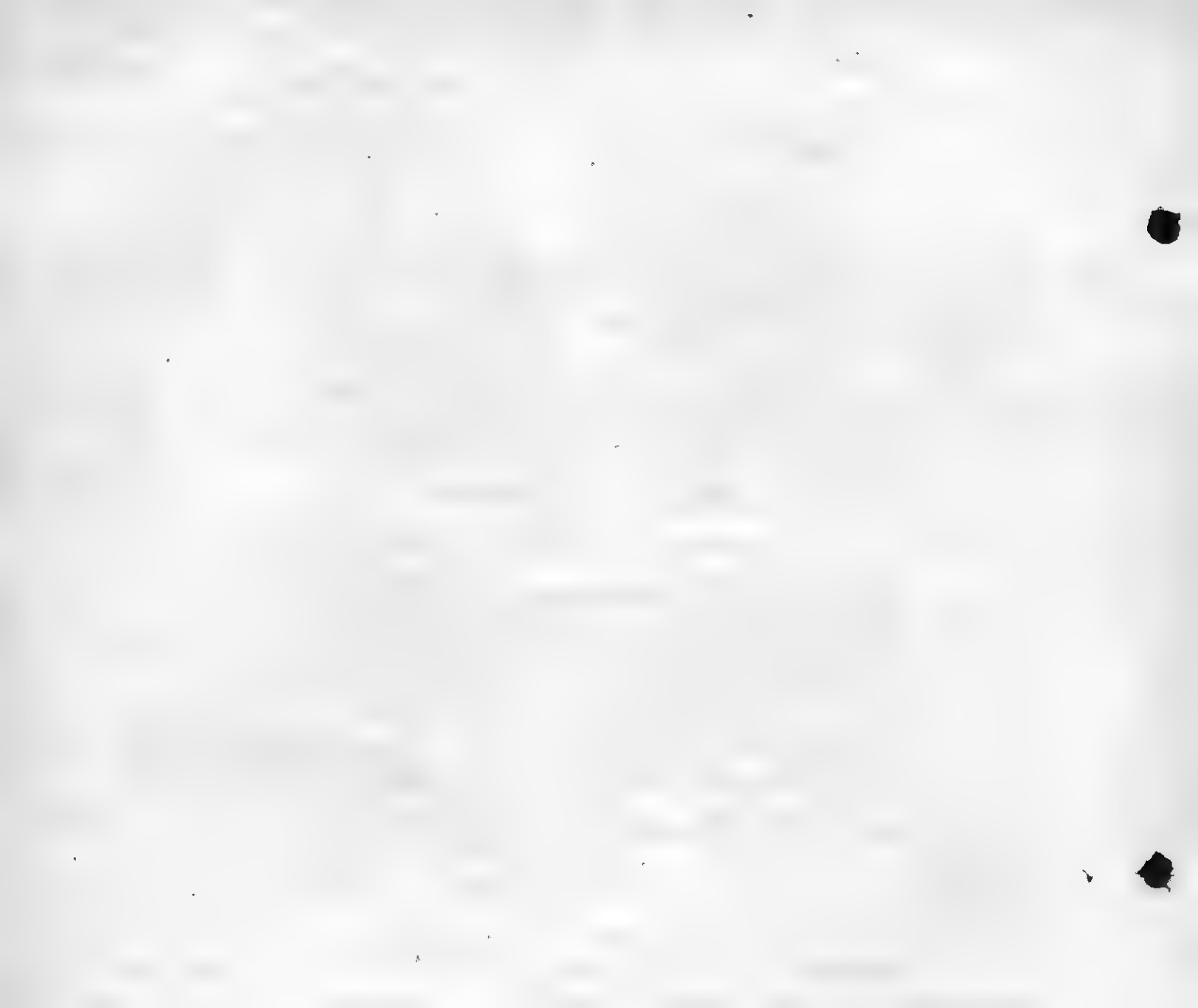


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
051113
CERTIFICATE OF DEATH
051111

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FURNACE TOWN</u> c. LENGTH OF STAY IN Bldg. <u>3 Wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GATHRY J. H. HOSP.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FURNACE TOWN</u> d. STREET ADDRESS <u>115 S. POTOMAC ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>C. ALLOTTE PAULINE DOWD</u>		4. DATE OF DEATH Month Day Year <u>APRIL 5 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/1894</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN C. DOWD</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE DOWD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>000-00-7080</u>	
17. INFORMANT <u>MRS. MAGGIE DOWD</u>		Address <u>FURNACE TOWN, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>general Arteriosclerosis and</u> (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Aug 1, 1958</u> , to <u>Apr 24, 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar 24, 1962</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Ditto III</u>		22b. DATE SIGNED <u>4/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, M.D.</u>		22d. ADDRESS <u>17 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/16/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LOST HILL CEM.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norment</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	



CERTIFICATE OF DEATH

05114

05112

1. PLACE OF DEATH
a. COUNTY Washington **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN b. 3 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garlock Mem. Home

2. USUAL RESIDENCE [Where deceased lived, if institution; Residence before admission]
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 2112 Virginia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) IDA CATHERINE DELLINGER-LONG
First Middle Last
4. DATE OF DEATH April 22 1962 19
Month Day Year
5. SEX Female **6. COLOR OR RACE** White
7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH Jan 17 1878
☒ WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (County & State, or foreign country) Downsville Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lewis Rhodes
14. MOTHER'S MAIDEN NAME Sarah Forthman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs Bertha Dellinger Williamsport Md
Address R # 1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myelogenous leukemia
204. } DUE TO
Conditions, if any, which } (b)
gave rise to immediate cause }
(e), stating the underlying } DUE TO
cause last. } (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Atherosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While Not While
at work at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from... Aug 1960 to April 22, 1962 that (II) (we) last saw the deceased alive on April 22, 1962 and that death occurred at 2 PM, from the causes and on the date stated above

22a. SIGNATURE M. E. Byrkit
22c. PHYSICIAN'S NAME (Type) M. E. Byrkit
22d. ADDRESS Williamsport Md
22b. DATE SIGNED 4-24-62

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 4/25/62
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery
23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman **ADDRESS** Hagerstown Md.
25a. REC'D BY REGISTRAR APR 26 '62
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05115

05113

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN TB 40 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1116 MANSIE RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BIRTHA LOUISE MANN		4. DATE OF DEATH APRIL 25 1962	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/1885	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 6 Hours 19 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN BREWER	
14. MOTHER'S MAIDEN NAME CATHERINE WINGER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO NONE		17. INFORMANT MR. CARL M. MANN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concussion y abdomen 15312 DUE TO Conditions, if any, which gave rise to immediate cause (b) Concussion y decumbent color (c) DUE TO PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ? INTERVAL BETWEEN ONSET AND DEATH 1 yr 7		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital), attended the deceased from 24 April 1962 to 25 April 1962 , that (I) (we) last saw the deceased alive on 21 April 1962 , and that death occurred at S.P.M. from the causes and on the date stated above.			
22a. SIGNATURE Edwin S. Hoackland		22b. DATE SIGNED 4/27/62	
22c. PHYSICIAN'S NAME (Type) Edwin S. Hoackland		22d. ADDRESS Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/28/62	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CLM.		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment		25a. REC'D BY REGISTRAR APR 30 '62	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05116

05114

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 48 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 HAGERSTOWN d. STREET ADDRESS 923 MT. AETNA ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOTTIE MANZELL MARKELL First Middle Last 4. DATE OF DEATH APRIL 7 1962 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH DECEMBER 29 1879 9. AGE (In years last birthday) 82 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER 11. BIRTHPLACE County & State or foreign country WASHINGTON MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BOWERS 14. MOTHER'S MAIDEN NAME IDA McCALL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO 16. SOCIAL SECURITY NO NONE 17. INFORMANT WILLIAM C MARKELL HAGERSTOWN MARYLAND Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF BLADDER DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 28 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROTIC HEART DISEASE. DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 2-17 , 19 62 to 4-7 , 19 62 that (I) (we) last saw the deceased alive on 4-3 , 19 62 , and that death occurred at 11:52 , from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi 22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22b. DATE SIGNED APR 10 '62 22d. ADDRESS 1500 Pa Ave Hagerstown	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-11-62	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND	
24 FUNERAL DIRECTOR'S SIGNATURE SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR APR 10 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05117

05115

1. PLACE OF DEATH
a. COUNTY WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LENA - RURAL
c. LENGTH OF STAY IN 1b 14 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BOONSBORO MD. R. 2

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LENA - RURAL
d. STREET ADDRESS BOONSBORO MD. R. 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) CLARENCE EDGAR MARTIN
4. DATE OF DEATH APRIL - 16 - 1962
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAY 21 - 1896
9. AGE (In years last birthday) 65 yrs. 10 Months 25 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER OWN FARM
10b. KIND OF BUSINESS OR INDUSTRY REID WASH. CO. MD. U.S.A.
11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME HARRY J. MARTIN
14. MOTHER'S MAIDEN NAME ANNIE CARPENTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES
16. SOCIAL SECURITY NO. WT-18-6608
17. INFORMANT MRS. BEULAH I. MARTIN Address BOONSBORO MD. R. 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interiselenotic Heart with
DUE TO decompensation
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) —
DUE TO (c) —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year April 3, 1962
Hour 19 e.m. p.m.
20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 3, 1962 to April 16, 1962, that (I) (we) last saw the deceased alive on April 14, 1962, and that death occurred at P.M. from the causes and on the date stated above.

22a. SIGNATURE G. W. LeVan
22b. DATE SIGNED 4/16/62
22c. PHYSICIAN'S NAME (Type) G. W. LeVan
22d. ADDRESS Boonsboro, Md
22e. MED. DIRECTOR ☒ STAFF PHYS. ☐

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF APRIL 19, 1962
23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY
23d. LOCATION (City, town or county) (State) BOONSBORO WASH. CO. MD.
24. FUNERAL DIRECTOR'S SIGNATURE John W. Baird ADDRESS BOONSBORO MD
25a. REC'D BY REGISTRAR APR 23 '62
25b. REGISTRAR'S SIGNATURE Clara S. Knaus

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
15M 7/61



1
X
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05118

05116

1. PLACE OF DEATH a. COUNTY VASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 55 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN RURAL d. STREET ADDRESS HAGERSTOWN RT.#7 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle WILLIAM Last McELWEE		4. DATE OF DEATH Month APRIL Day 26 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER & OWNER		10b. KIND OF BUSINESS OR INDUSTRY DAIRY PRODUCTS CO.	9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC R. McELWEE		14. MOTHER'S MAIDEN NAME MARY BREWER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-9640	
17. INFORMANT MRS. RUTH B. McELWEE		Address RT.#7 HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary artery disease with angina (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 24 hr. Indefinite
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 25, 1961, to April 26, 1962, that (I) (we) last saw the deceased alive on April 26, 1962, and that death occurred at 4:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED April 27, 1962	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 4/29/62	23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEM.	23d. LOCATION (City, town or county) (State) SMITHSBURG MD.

24. FUNERAL DIRECTOR'S SIGNATURE **W. J. Norment, Hagerstown, Md.** ADDRESS
25a. REC'D BY REGISTRAR **MAY 2 '62** DATE
25b. REGISTRAR'S SIGNATURE **Arthur S. Thomas**

FOR STATE
HEALTH DEPT.

05119

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05117

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>151 WEST WASHINGTON ST.</u> e. IS RE-INTERMENT ON A FARA YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT EDWARD MORRISON</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 22, 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER - 10 - 1923</u>
9. AGE (In years last birthday) <u>38</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. <u>6 12</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC - FARM IMPLEMENT CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRED N. MORRISON</u>		14. MOTHER'S MAIDEN NAME <u>EDNA R. JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>215-20-8942</u>	
17. INFORMANT <u>FRED N. MORRISON</u>		Address <u>MIDDLEBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation (By Smoke)</u> DUE TO <u>9150</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2nd. And 3rd. Degree Burns Involving Entire Body.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Few minutes.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Found on bed, mattress completely burned.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11 - 11-22- 1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. W. Ditto, Jr.</u>		DATE SIGNED <u>April 24, 1962</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 25, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baer</u>		ADDRESS <u>BOONSBORO MD</u>	
24a. REC'D BY REGISTRAR <u>APR 27 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
05120				Ivens O & Williams 5/1/62				05118							
1. PLACE OF DEATH a. COUNTY Washington				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN b. 5 weeks				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash County Hospital			
3. NAME OF DECEASED (Type or print) WILLIAM HAMILTON MORROW				5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 1894				9. AGE (in years last birthday) 67 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				11. BIRTHPLACE (County & State or foreign country) W. Va			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Ruthvan W. Morrow				14. MOTHER'S MAIDEN NAME Lillie M. Muse				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes			
16. SOCIAL SECURITY NO. 214-09-9634				17. INFORMANT Miss Josephene Morrow				18. CAUSE OF DEATH (Only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Agranulocytic Leukemia 204-4 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1962 to April 10, 1962 that (I) (we) last saw the deceased alive on April 10, 1962, and that death occurred at 6:15 P.M. from the causes and on the date stated above.				22a. SIGNATURE Dr. E.W. Ditto, Jr.			
22b. DATE SIGNED April 11, 1962				22c. PHYSICIAN'S NAME (Type) Dr. E.W. Ditto, Jr.				22d. ADDRESS 215 W. Washington St., Hagerstown, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/12/62				23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery				23d. LOCATION (City, town or county) Shepherdstown Jefferson6			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR APR 13 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. DATE			

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VR A15 (4)
15M 7 61

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if not full-time residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u>		e. STREET ADDRESS <u>805 Dewey Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERT JEREMIAH PEDDICORD</u>		4. DATE OF DEATH <u>April 11, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1916</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland,</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Walter D. Peddicord</u>		14. MOTHER'S MAIDEN NAME <u>Goldie D. Somerville</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 2</u>	
17. INFORMANT <u>Joseph D. Peddicord, 1312 Hamilton Blvd.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
<p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolization; Left Massive</u> <u>936.7</u> DUE TO <u>Acute Subdural Hematoma, Right Hemisphere</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Contusions Of Right Cerebral Hemisphere</u> DUE TO <u>Hemorrhagic Necrosis With Cyst Formation Right</u> (c) <u>Temporal Lobe.</u></p>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>April 11, 1962</u> Hour <u>4:11</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Jail Alley.</u>		20f. (City or town) <u>Hagerstown, Washington, Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or country) <u>Hagerstown, Wash. Co., Md.</u>	
23. FUNERAL DIRECTOR <u>Andrew K. Coffman Hagerstown, Maryland.</u>		24a. REC'D BY REGISTRAR <u>APR 19 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05123

CERTIFICATE OF DEATH

Reg. Dist. No. 05121

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Pa.</u>		75X3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Nursing Home</u>		d. STREET ADDRESS <u>241 S. Allison St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mae</u> First <u>J.</u> Middle <u>Pentz</u> Last		4. DATE OF DEATH <u>April 15</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR: Months <u>8</u> Days <u>7</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Huntingdon Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas McKelvey</u>		14. MOTHER'S MAIDEN NAME <u>Alice Hicks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>1004</u>	
17. INFORMANT <u>Stanley Pentz - Greencastle, Pa.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast.</u> DUE TO <u>X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12, 1962</u> to <u>April 15, 1962</u> , that I last saw the deceased alive on <u>April 14, 1962</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>4/17/62</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>4/18/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u> ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 1962</u>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05124

CERTIFICATE OF DEATH

05122

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> c. LENGTH OF STAY in lb <u>6 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gateway Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> d. STREET ADDRESS <u>417 Brewer Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Clayton</u> Last <u>Porter</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1881</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron works</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metal worker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bendersville Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Elmer Porter</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Petrs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-3283A</u>	
17. INFORMANT <u>Mrs. Virginia A. Syncire</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.0</u> <u>Coronary Sclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1, 1962</u> to <u>April 22, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 21, 1962</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.			
21a. SIGNATURE <u>David R. Brewer M.D.</u>		21b. DATE SIGNED <u>4/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		22d. ADDRESS <u>Clear Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Hest</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	



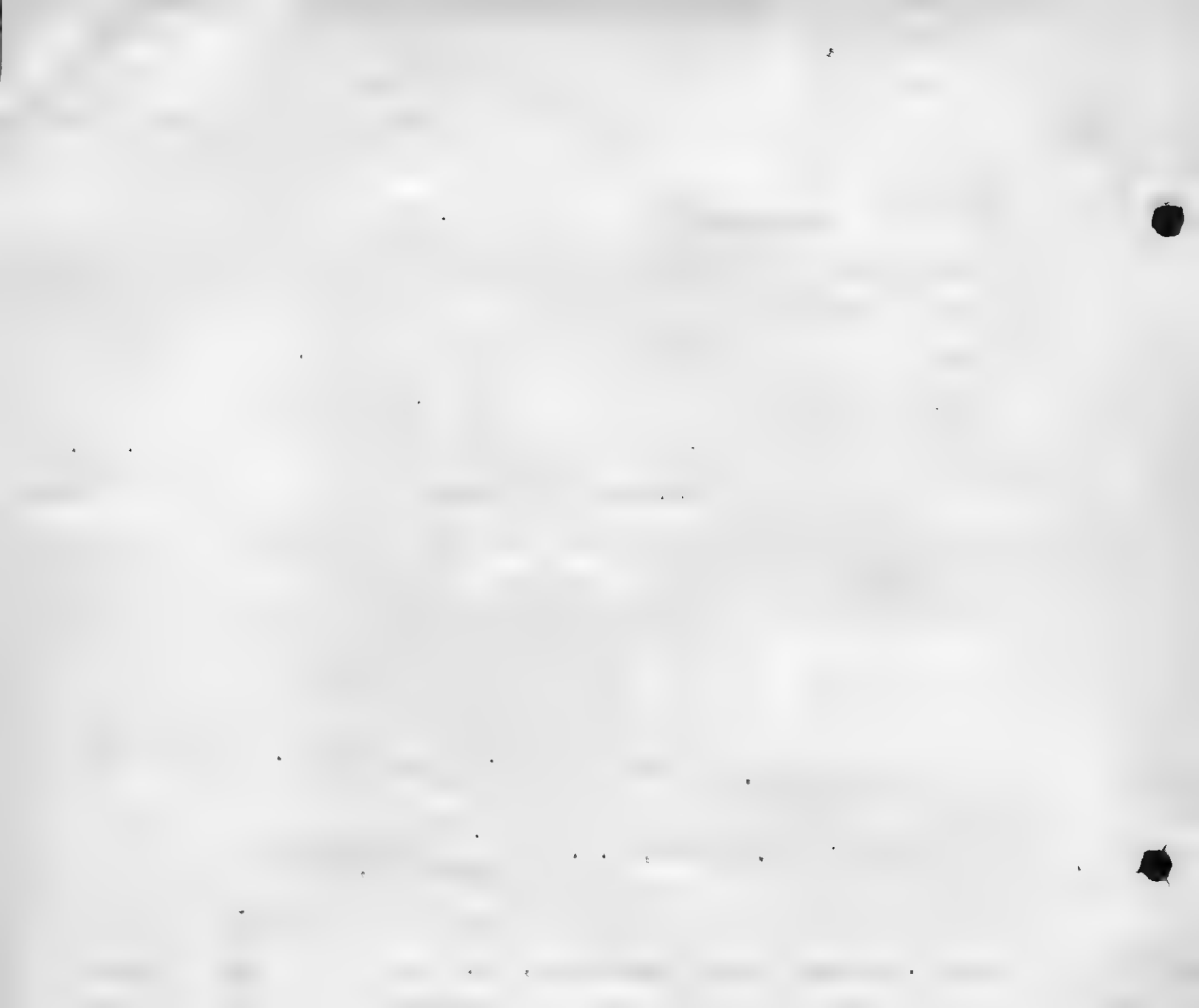
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05125
05123
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>45 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>19 W. Magnolia Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary</u> <u>Cassandra</u> <u>Potterfield</u> e. SEX <u>Female</u> f. COLOR OR RACE <u>White</u> g. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> h. DATE OF BIRTH <u>May 30, 1911</u> i. AGE (in years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		4. DATE OF DEATH Month Day Year <u>April</u> <u>5</u> <u>1962</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State or foreign country) <u>Waynesboro, Pa.</u> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Sidney Ellis</u> 14. MOTHER'S MAIDEN NAME <u>Lulu Forney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-09-2764</u> 17. INFORMANT <u>Charles Potterfield</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) <u>Rupture of aneurysm of left vertebral artery</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>39 hours</u> <u>39 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (XXXXXX) attended the deceased from <u>Apr. 3, 1962</u> to <u>Apr. 5, 1962</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Apr. 5, 1962</u> , and that death occurred at <u>2:45 pm</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>4-6-62</u>	
22a. SIGNATURE <u>William T. Layman, M.D.</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		22d. ADDRESS <u>5 Public Square Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-8-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 23d. LOCATION (City, town or county) <u>Hagerstown, Md.</u> (State) _____		25a. REC'D BY REGISTRAR <u>APR 9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u> ADDRESS <u>Hagerstown, Md.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05126
05124

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN b. 6 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY WASHINGTON
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 919 W FRANKLIN ST. HAGERSTOWN MD
d. STREET ADDRESS 919 W FRANKLIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Middle Last
DOROTHY MARIE RAIFSNIDER

4. DATE OF DEATH
Month Day Year
APRIL 30 19 62

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH JULY 6 1900
8. WIDOWED ☐ DIVORCED ☐

9. AGE (In years last birthday) 61 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESLERK
11. BIRTHPLACE (County & State, or foreign country) MANSFIELD OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME MILFORD J BOUGHTON
14. MOTHER'S MAIDEN NAME EDNA BELL ROGERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO
16. SOCIAL SECURITY NO. 217-10-3270
17. INFORMANT HARVEY E RAIFSNIDER HAGERSTOWN MARYLAND

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 171X Uterine Carcinoma Cervix
Conditions, if any, which gave rise to immediate cause (b) 10 months
(a), stating the underlying cause last. (c) 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Breast

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 16 March 1962 to 30 April 1962 that (I) (we) last saw the deceased alive on 30 April 1962 and that death occurred at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE Frank E Brumback M.D.
22b. DATE SIGNED 1 May 62
22c. PHYSICIAN'S NAME (Type) FRANK E BRUMBACK M. D.
22d. ADDRESS 170 W WASHINGTON ST. HAGERSTOWN MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 5-2-62
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY
23d. LOCATION (City, town or county) HAGERSTOWN MARYLAND (State)

24. FUNERAL DIRECTOR'S SIGNATURE SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND
25a. REC'D BY REGISTRAR DATE MAY 3 '62
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05127 CERTIFICATE OF DEATH 05125

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN TB <u>3 HOURS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>APPLETOWN RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL DIANE REED</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 15 - 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 20 - 1958</u>
9. AGE (in years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. Co. MD.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL REED</u>		14. MOTHER'S MAIDEN NAME <u>ELAINE DE WITT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DANIEL REED BOONSBORO MD. R. 2</u>		Address <u>BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u>			
DUE TO (b) <u>Bilateral Cerebral pneumonia</u>			
DUE TO (c) <u>Myasthenia gravis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 1/2 hours</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 14/15</u> to <u>4/15</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>62</u> , and that death occurred <u>3:50 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George Jennings</u>		22b. DATE SIGNED <u>4/17/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>George Jennings</u>		22d. ADDRESS <u>1364 Washington St Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 18 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. Co. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u>	
ADDRESS <u>BOONSBORO MD.</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

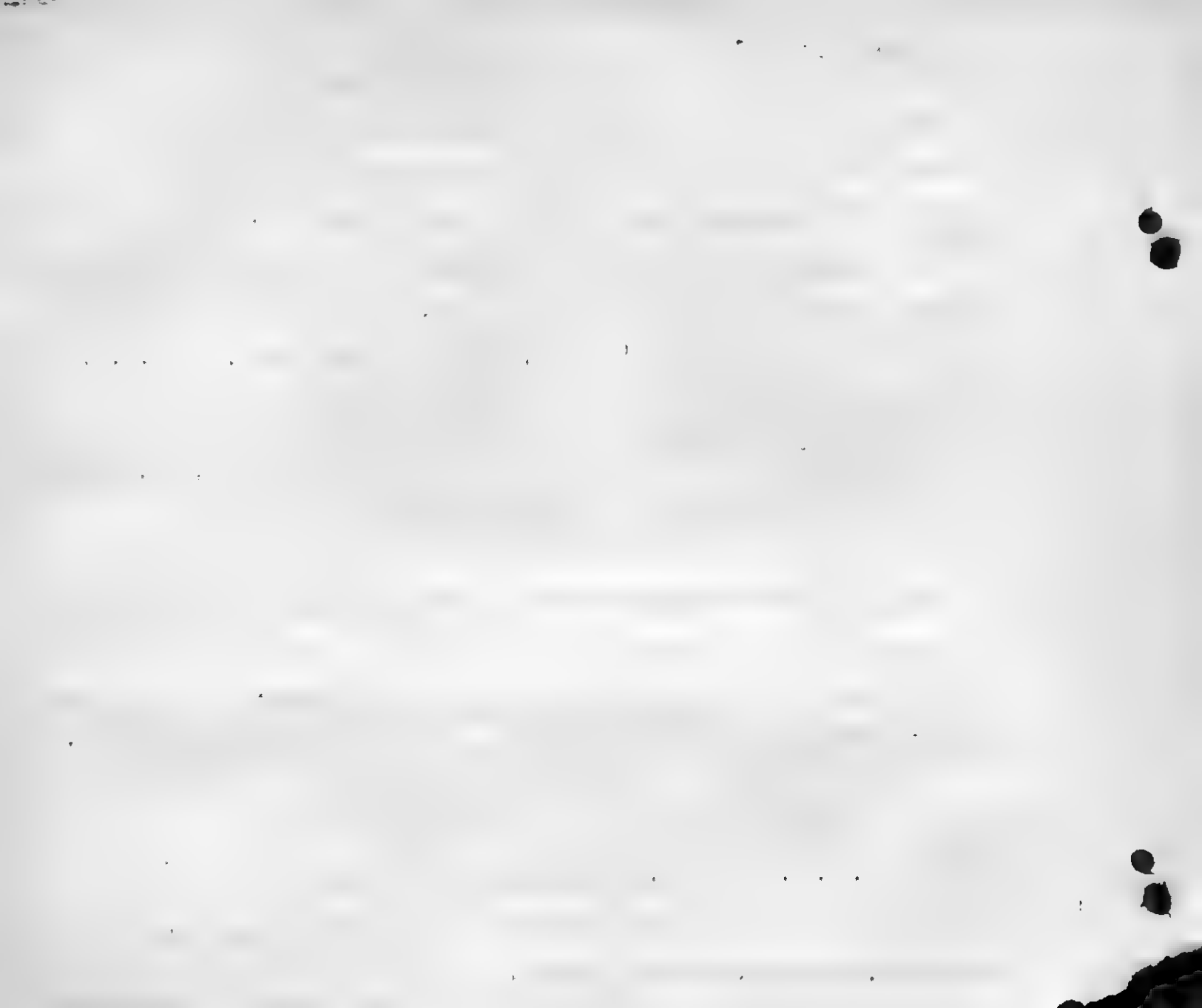
TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

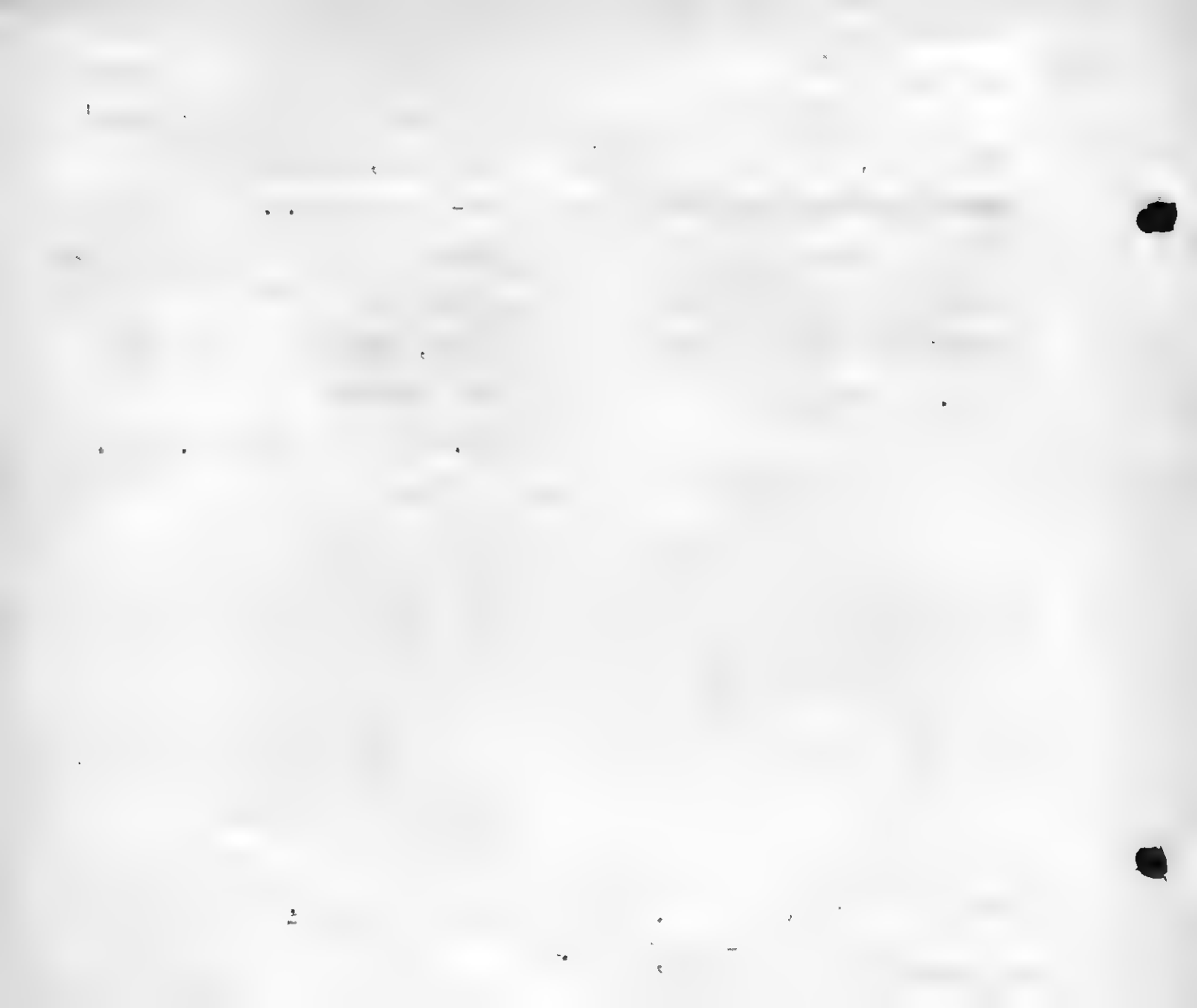
VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05128		05126	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Cty. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1369 Marshall St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lelia Caroline Reigh</u>		4. DATE OF DEATH <u>April 15 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2, 1925</u>	
9. AGE (in years last birthday) <u>37 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stouffer's Rest. St James Wash Co Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Luther Wine</u>		14. MOTHER'S MAIDEN NAME <u>Anna Lee Cochenour</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 20-9879</u>	
17. INFORMANT <u>Donald Reigh, 1369 Marshall St Hagerstown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Comminuted Basilar Skull Fracture</u> DUE TO <u>Compounded Through Cribriform Plate & Ethmoid Sinus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lepto Meningitis Acute</u> DUE TO (c) <u>Cerebral Congestion & Edema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Passenger in Taxi that collided with a truck.</u>	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>7:15 - 4-3- 19 62</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
20f. (City or town) <u>Hagerstown, Washington, Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. L. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or country) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR <u>Andrew K. Coffman, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 18 62</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE	

MEDICAL CERTIFICATION





05131

CERTIFICATE OF DEATH

05129

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>70 YF3.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>308 N. CANNON AVE.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASH.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>730 N. MULETERRY ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>LORETTA</u> Last <u>BOURKE</u> 4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1966</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6/6/1900</u> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>VALENTIA VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN LONG</u> 14. MOTHER'S MAIDEN NAME <u>ELIZABETH BARTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>20-88-8479</u> 17. INFORMANT <u>M. J. JILL</u> Address <u>...</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>4500</u> (e), stating the underlying cause last. (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Fracture Colles, right of about six weeks duration</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <u>4-17-62</u> Hour a.m. <u>12</u> p.m. <u>12</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>2-21-61</u> 20f. (City or town) <u>Hagerstown</u> (County) <u>MARYLAND</u> (State) <u>MARYLAND</u>		21. I certify that (I) (this hospital) attended the deceased from <u>4-17-62</u> to <u>death</u> that (I) (we) last saw the deceased alive on <u>4-17-62</u> and that death occurred <u>4-18-62</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Paul Harrison</u> 22c. PHYSICIAN'S NAME (Type or print) <u>Robert F. KEADLE</u>		22b. DATE SIGNED <u>4-19-62</u> 22d. ADDRESS <u>Hagerstown Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-19-66</u> 23b. DATE THEREOF <u>4-19-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>W. J. NORMENT</u>		23d. LOCATION (City, town or county) <u>Hagerstown Md.</u> (State) <u>MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. NORMENT</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director.

05132

CERTIFICATE OF DEATH

Reg. Dist. No. 05130

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co., Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Rosenberry</u> Last <u>Rosenberry</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 25, 1927</u>
9. AGE (In years last birthday) yrs. <u>34</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Central City, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles William Deneen</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Mae Kirchner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Bertha Logsdon Hyndman, Pa. RD #1</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive intestinal hemorrhage</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral aneurysm</u> DUE TO <u> </u> (c) <u>Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>year</u> <u>year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>12 April</u> , 19 <u>62</u> , to <u>16 April</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>15 April</u> , 19 <u>62</u> , and that death occurred at <u>11:54 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>4/14/62</u> ACTUAL SIGNATURE <u>Evelyn A. Houchens</u> M.D. <u>115 W. Wash St</u> PHYSICIAN'S NAME (Type) <u>Evelyn A. Houchens</u> <u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 19, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Lueger</u>		24a. REC'D BY REGISTRAR DATE <u>APR 19 62</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN TB 10 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1207 J. MULLEN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ANN SAMBELL First Middle Last		4. DATE OF DEATH Month Day Year APRIL 17 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/86 9. AGE (in years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME HARVEY MYERS		14. MOTHER'S MAIDEN NAME ANNIE WOLF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE 17. INFORMANT Address HAGERSTOWN MD. MP. REGINALD F. SAMBELL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Collapse (b) Cerebral vascular accident (c) Arteriosclerosis Gen. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 16 1962, to May 17 1962, that (I) last saw the deceased alive on May 16 1962, and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Louis S. Graff 22c. PHYSICIAN'S NAME (Type) LOUIS GRAFF		22b. ADDRESS 119 E. Antietam	22d. DATE 4/17/62
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/19/62	23c. NAME OF CEMETERY OR CREMATORY CHURCH BROADFORDING 23d. LOCATION (City, town or county) WASHINGTON CO. MD. (State)
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 23 1962 25b. REGISTRAR'S SIGNATURE Louis S. Graff	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. After the death certificate is retained by the hospital or attending physician, it may be retained by the hospital or attending physician for a period of 4 months after the date of death. After this period, the death certificate may be destroyed. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05132

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>710 W. WASHINGTON ST.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>710 W. WASHINGTON ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE JOHN SCHMIDT</u>		4. DATE OF DEATH Month Day Year <u>APRIL 5 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1874</u>
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months Days <u>37</u>	
IF UNDER 24 HRS. Hours Min. <u>37</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ANTIQUE DEALER OWN BUSINESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GOTTLIEB SCHMIDT</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN ANN LAIBACK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>W.S. JAMES JOHNSON</u>		Address <u>HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4508</u> DUE TO <u>gen'l arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>INTERVAL BETWEEN ONSET AND DEATH <u>sev. yrs.</u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>ON 4/5/62</u> 19 <u>at 11:30 PM</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard N. Weeks</u> M.D.		22b. DATE SIGNED <u>4/6/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M. D.</u>		22d. ADDRESS <u>136 N. Potomac Street</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/8/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>POST HILL CEM.</u>	23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.T. Norment, Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05136

05134

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARAMOUNT (RURAL)</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HAGERSTOWN RD #6</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARAMOUNT X HAGERSTOWN RD #6</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH M. SHUCK</u>		4. DATE OF DEATH <u>APRIL 23 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 14 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER - SCHOOLS</u>		11. BIRTHPLACE (State or foreign country) <u>FRANKLIN CO. PA</u>	
13. FATHER'S NAME <u>HARMON L SHUCK</u>		14. MOTHER'S MAIDEN NAME <u>MARY M BURKETT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-3798</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombotic Occlusion, Anterior Descending Branch</u> DUE TO <u>Of Left Coronary Artery, Recent</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary Atherosclerosis, Generalized</u> DUE TO (c) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps at his home.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>12:50 P.M.</u> <u>4-23-1962</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. LOCATION (City, town, or country) (State) <u>Hagerstown Rd #6, Washington, Md.</u>	
ACTUAL SIGNATURE <u>[Signature]</u> EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <u>April 25/1962</u>		DATE SIGNED <u>April 24, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View</u>		22d. LOCATION (City, town, or country) (State) <u>State Line Md</u>	
23. FUNERAL DIRECTOR <u>A.E. Minnick</u> ADDRESS <u>Green castle Pa</u>		24a. REC'D BY REGISTRAR <u>APR 26 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

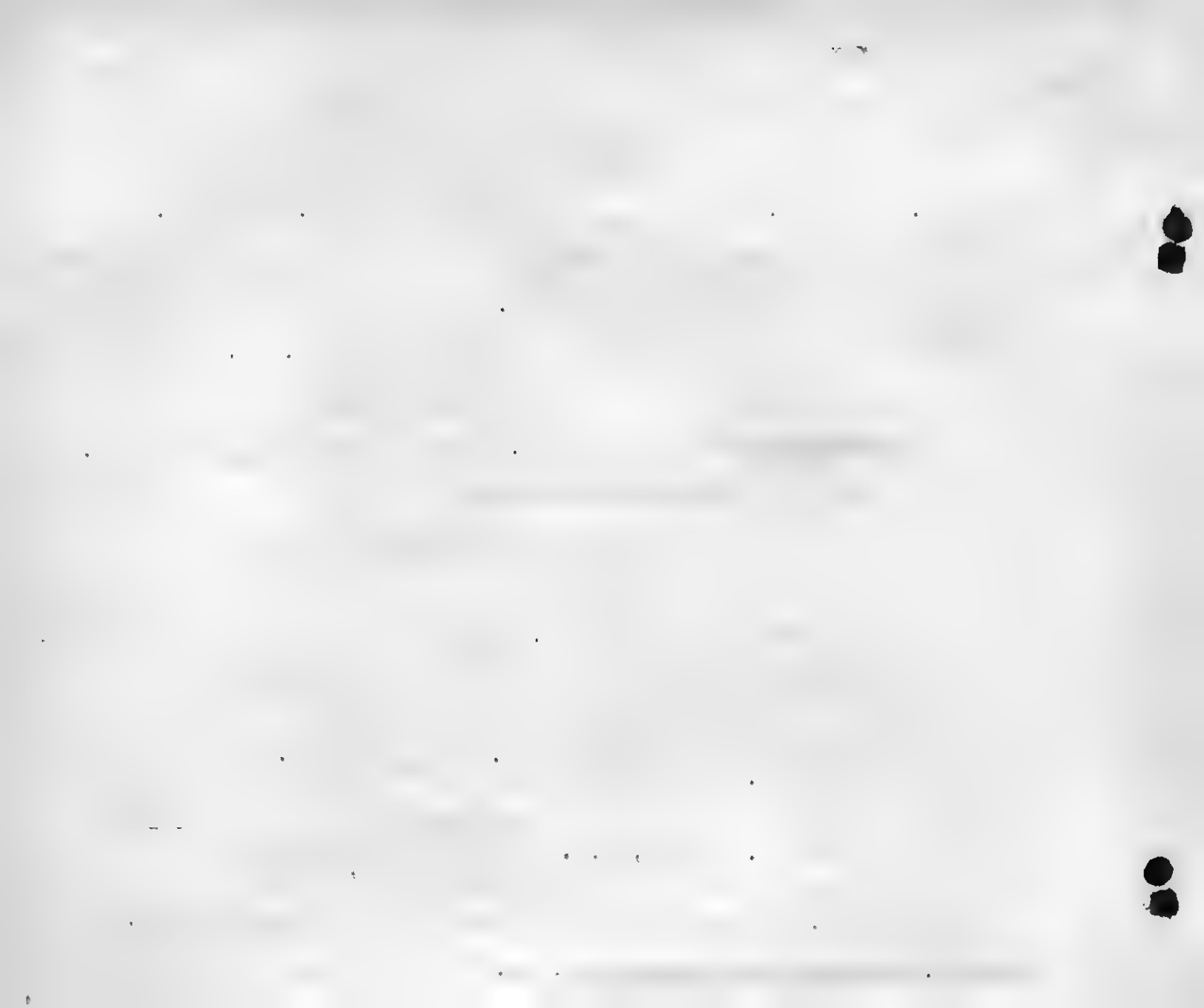
VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05137
05135

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 55 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 104 E. First St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 104 E. First St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Henry Smith First Middle Last 4. DATE OF DEATH April 8 1962 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Sept. 28, 1874 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years, last birthday) 87 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman 10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory 11. BIRTHPLACE (County & State, or foreign country) Martinsburg, W. Va. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Phillip Smith 14. MOTHER'S MAIDEN NAME Sarah Jane Henry	
15. WAS DECEASED EVER IN U.S. ARMY, NAVY, OR AIR FORCE? No (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 214-09-5467a 17. INFORMANT Mrs. Velda Grimes Hagerstown, Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency 4'20.0 DUE TO Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate, suspected. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (we) attended the deceased from Apr. 1 1962 to Apr. 8 1962 that (I) (we) last saw the deceased alive on Apr. 7 1962 and that death occurred at 6:15 pm from the causes and on the date stated above.			
22a. SIGNATURE William T. Layman, M.D. M.D. 22b. DATE SIGNED 4-9-62		22c. ADDRESS 5 Public Square Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 10, 62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md. ADDRESS		25a. REC'D BY REGISTRAR APR 11 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Thoma	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. The law also requires that the death certificate be filed with the funeral director, page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05138
05136

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. c. LENGTH OF STAY IN 1b 38 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland d. STREET ADDRESS 340 Blooms Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jack (no) Stokes		4. DATE OF DEATH April 17 1962	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24 1900
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 10 Days 12	
11. IF UNDER 24 HRS. Hours 10 Min. 12		12. CITIZEN OF WHAT COUNTRY? USA.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Concrete Works	
11. BIRTHPLACE (County & State, or foreign country) Williamston, N.C.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Thomas Stokes		14. MOTHER'S MAIDEN NAME Winnie Spruill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 579-07-7453	
17. INFORMANT Miss Fannie Stokes		18. ADDRESS 5456 16th. Ave Newark, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 443X DUE TO (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE. DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 10-12 DAYS	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. DIABETES MELLITUS 2. Uremia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 6 1962 , to April 17 1962 , that (I) (we) last saw the deceased alive on 17 April 1962 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. Noel Fender, M. D.		22b. DATE SIGNED 20 April 1962	
22c. PHYSICIAN'S NAME (Type) Wm. Noel Fender, M. D.		22d. ADDRESS 218 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-1962	
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City, town or county) (State) Williamston, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr Hagerstown Md		25a. REC'D BY REGISTRAR APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. DATE APR 23 '62	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05139

05137

1. PLACE OF DEATH
a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 3 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL (WOLFESVILLE RD) d. STREET ADDRESS BOONSBORO MD. R.2 e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) DELLA B. STONEBERGER 4. DATE OF DEATH APRIL - 15, 1962

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH FEBRUARY 17-1899 9. AGE (In years last birthday) 63 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 11. BIRTHPLACE, County & State, or foreign country STANLEY VIRGINIA 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME JAMES ALSHIRE 14. MOTHER'S MAIDEN NAME HESTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT HARRY W. STONEBERGER SR. BOONSBORO MD. R.2 Address 'NO RECORD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thyroid Storm
DUE TO Grave's Disease
Conditions, if any, which gave rise to immediate cause (b) Grave's Disease
DUE TO Grave's Disease
(c) Grave's Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Confusion

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18.) None

20c. TIME OF INJURY Month Day, Year June 19, 1960 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Boonsboro Md

21. I certify that (I) (this hospital) attended the deceased from June 19, 1960 to April 15, 1962 that (I) (we) last saw the deceased alive on April 14, 1962 and that death occurred 4 P.M. from the causes and on the date stated above

22a. SIGNATURE Joseph Secondary M.D. 22b. DATE SIGNED APR 23 '62

22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARY 22d. ADDRESS Boonsboro Md

23a. BURIAL CREMATION REMOVAL (Specify) BURIAL 23b. DATE THEREOF APRIL 18, 1962 23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY 23d. LOCATION (City, town or county) (State) BOONSBORO WASH. CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE John L. East ADDRESS Boonsboro MD 25a. REC'D BY REGISTRAR APR 23 '62 25b. REGISTRAR'S SIGNATURE John L. East

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05140

05138

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY in lb <u>8 mos. 1 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> d. STREET ADDRESS <u>235 W. Second St.</u> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nettie</u>		4. DATE OF DEATH Last Middle First <u>Warnick</u>		Month Day Year <u>April 14 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>August 10, 1869</u>		9. AGE (In years last birthday) <u>92</u> yrs IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY _____			
11. FATHER'S NAME <u>William W. Stringer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		15. SOCIAL SECURITY NO. _____		16. INFORMANT Address <u>Mr. Clyde Warnick 231 W. Second St. Waynesboro, PA.</u>			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>Diabetes Mellitus</u> (c) <u>Arterio Sclerosis Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Hour _____ e.m. _____ p.m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 6, 1961</u> to <u>April 14, 1962</u> That (I) (we) last saw the deceased alive on <u>4/14/62</u> and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>I. B. Brown</u> M.D.				22b. DATE SIGNED <u>APR 19 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>I. B. BROWN M.D.</u>				22d. ADDRESS <u>Waynesboro, Pa.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/17/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Gure</u>		25a. REC'D BY REGISTRAR DATE <u>APR 19 1962</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years after the death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05141 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05139

1. PLACE OF DEATH a. COUNTY Washington County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. Va. b. COUNTY Morgan c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sleepy Creek d. STREET ADDRESS 85X-3		
3. NAME OF DECEASED (Type or print) Isaac Ray Watson			4. DATE OF DEATH Month Day Year April 7, 1962		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/62	9. AGE (In years last birthday) yrs Months Days 2 4	IF UNDER 1 YEAR Months Days 2 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Julius H. Watson			12. CITIZEN OF WHAT COUNTRY? U.S.		
14. MOTHER'S MAIDEN NAME Juanita K. Fox			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. none			17. INFORMANT Address Juanita K. Watson Sleepy Creek		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Interstitial Pneumonia 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH 20 hours					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year ____ 19 ____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>[Signature]</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/62		22c. NAME OF CEMETERY OR CREMATORY Shriver's Cemetery	
23. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS <i>[Address]</i>		24a. REC'D BY REGISTRAR APR 10 '62	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24c. LOCATION (City, town, or country) (State) Morgan County, W. Va.					

2176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05142 CERTIFICATE OF DEATH 05140

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>6 1/2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1st</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Douglasburg</u> d. STREET ADDRESS <u>Old Hanover Road.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EIVA</u> Middle <u>CEDONIA</u> Last <u>WATTS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1869</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hamstein Carroll Co. U.S.A.</u>	
11. FATHER'S NAME <u>B. JACKSON</u>		12. MOTHER'S MAIDEN NAME <u>S. B. BENSON</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. SOCIAL SECURITY NO. <u>none</u>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ac. myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		16. INFORMANT <u>Mrs. MARGIE Benge/Hagerstown, Md.</u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
17. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. PLACE OF INJURY (Home, farm, factory, street, etc.)		22. (City or town) (County) (State)	
23. I certify that (I) (this hospital) attended the deceased from <u>4/27/62</u> to <u>4/27/62</u> , that (I) (we) last saw the deceased alive on <u>4/27/62</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
24. SIGNATURE OF PHYSICIAN <u>Ralph Young</u>		25. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE <u>4/27/62</u>	
26. PHYSICIAN'S NAME (Type)		27. ADDRESS	
28. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		29. DATE THEREOF <u>4/29/62</u>	
30. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cem</u>		31. LOCATION (City, town or county) (State) <u>BALTO. CO. MARYLAND</u>	
32. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Echhardt</u>		33. ADDRESS <u>Owings Mills, Maryland</u>	
34. REC'D BY REGISTRAR <u>APR 30 '62</u>		35. REGISTRAR'S SIGNATURE <u>Charles S. Hauer</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05143

05141

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>4</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1212 Glenwood Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY EARL WEAGLEY SR.</u>		4. DATE OF DEATH <u>April 24, 1962</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>May 26, 1892</u>		9. AGE (in years last birthday) <u>69</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Rouzersville, Pennsylvania.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>William Weagley</u> 14. MOTHER'S MAIDEN NAME <u>Ida Kinsel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-3455</u>		17. INFORMANT <u>Florence M. Sheaffer, 600 1/2 Guilford Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Uremia</u> (b) <u>Nonfunctioning kidney, right; stag-horn calculus right kidney</u> (c) <u>Anemia secondary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Advanced chronic osteitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>1</u> p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 6, 1962 to April 24, 1962, that (I) (we) last saw the deceased alive on April 24, 1962, and that death occurred at 1 PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>P. B. Kneisley</u>		22b. DATE SIGNED <u>4/25/62</u>		22c. PHYSICIAN'S NAME (Type) <u>P. B. Kneisley, M.D.</u>			
22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/27/62</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Wetlys Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>GREENSBURG, Pa.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			
25a. REC'D BY REGISTRAR <u>APR 26 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kneisley</u>		25c. ADDRESS			

MEDICAL CERTIFICATION

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE SIGNED BY A PHYSICIAN WITHIN 24 HOURS AFTER DEATH. THE PHYSICIAN MAY BE THE ATTENDING PHYSICIAN OR ANOTHER PHYSICIAN WHO HAS BEEN CONSULTED BY THE ATTENDING PHYSICIAN. THE PHYSICIAN MUST SIGN THE CERTIFICATE IN THE PRESENCE OF THE FUNERAL DIRECTOR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE PHYSICIAN, THE FUNERAL DIRECTOR MUST SIGN IT. THE FUNERAL DIRECTOR MUST SIGN THE CERTIFICATE IN THE PRESENCE OF THE PHYSICIAN. THE FUNERAL DIRECTOR MUST SIGN THE CERTIFICATE IN THE PRESENCE OF THE PHYSICIAN. THE FUNERAL DIRECTOR MUST SIGN THE CERTIFICATE IN THE PRESENCE OF THE PHYSICIAN.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05142

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN MD 22 Yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 48 McKee Ave				d. STREET ADDRESS 48 McKee Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HERMAN		First		Middle		Last	
4. DATE OF DEATH April 28 1962		Month		Day		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 15 1901	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Branch Manager Sealtest Foods		10b. KIND OF BUSINESS OR INDUSTRY Lone Star Calhoun Co		11. BIRTHPLACE (State or foreign country) So. Car.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William Daniel Weeks		14. MOTHER'S MAIDEN NAME Rowena Zeagler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-8556	
17. INFORMANT Mrs Beatrice A. Weeks 48 McKee Ave Hagerstown Md.		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Occipital Skull Fracture DUE TO Cerebral Contusion, Rt. Frontal And Occipital Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lobes DUE TO Subarachnoid Hemorrhage (c) Aspiration Of Vomitus		INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Fell backwards down stairs at his home.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home	
20c. TIME OF INJURY Hour 10:30 p.m. Month, Day, Year 4-28-62 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 30, 1962	
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Hagerstown Wash Co Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/62		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or country) (State) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 2 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05145

CERTIFICATE OF DEATH

05143

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 4 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Smithsburg d. STREET ADDRESS RFD	
3. NAME OF DECEASED (Type or print) Lydia Elizabeth Wiles		4. DATE OF DEATH 4 22 1962	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1882	
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? Frederick, Md.	
13. FATHER'S NAME Christian Gerlach		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Roy L. Wiles, RFD 2, Smithsburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Arterio-sclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Arterio-sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 22, 1958 to April 22, 1962 that (I) last saw the deceased alive on April 22, 1962 and that death occurred at 6:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D.		22b. DATE SIGNED April 22 1962	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-24-62	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		25a. REC'D BY REGISTRAR APR 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Evans			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05146 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05144

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 wks. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 Hagerstown d. STREET ADDRESS 601 W. Franklin Street	
3. NAME OF DECEASED (Type or print) JEFFERIES ALLEN WILLIAMS		4. DATE OF DEATH April 3, 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 31, 1911 50
9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 50 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Mechanic	
11. BIRTHPLACE (State or foreign country) Meridian, Mississippi. USA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Claude Williams		14. MOTHER'S MAIDEN NAME Ruby Dowdle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Margaret Williams, 601 W. Franklin St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis following gunshot 9/17.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) wounds (6) of abdomen DUE TO (c) Uremia & Pneumonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) 12 day		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Shot in abdomen		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3-19 1962		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> At work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Washington Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Andrew K. Coffman NAME (Type) Andrew K. Coffman		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Hagerstown Wash. Co. Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/62	
22c. NAME OF CEMETERY OR CREMATORY Hagerstown Wash. Co. Md		22d. LOCATION (City, town, or country) (State) Hagerstown Wash. Co. Md	
23. FUNERAL DIRECTOR Andrew K. Coffman, Hagerstown, Maryland		24a. REC'D BY REGISTRAR APR 9 '62	
24b. REGISTRAR'S SIGNATURE Christus S. Means		DATE SIGNED 4/3/62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05147
05145
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>200 Taylor Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Blanche</u> Last <u>Wolfe</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>2</u> Hours <u>19</u> M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bakersville, Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Sellers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. J. E. Pleasant</u>		Address <u>R# 4 Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>241X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute congestive heart failure</u> (c) <u>Chronic Asthma</u> DUE TO <u>241X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>5-6 hrs</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on..... <u>4/2/62</u>, 19 <u>62</u> , and that death occurred at..... <u>2:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE <u>4/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Noel Fender, M. D.</u>		22d. ADDRESS <u>218 N. Potomac St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/4/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Funkstown Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>APR 5 1962</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

Wm. G. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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05146

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b. 5 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 901 Oak Hill Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL BOSTETTER YOUNG				4. DATE OF DEATH Month Day Year April 14 1962 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21 1895	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Own Properties		11. BIRTHPLACE (County & State, or foreign country) Funkstown Wash Co Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph A. Young Sr.				14. MOTHER'S MAIDEN NAME Mary Bostetter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.# 1				16. SOCIAL SECURITY NO. 219-36-4624			
17. INFORMANT John B. Young				Address 1141 Hamilton Blvd Hagerstown Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Thrombosis DUE TO (c) 4 days 4 days				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1962 to April 14, 1962 that (I) (we) last saw the deceased alive on April 14, 1962, and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/16/62	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman				22d. ADDRESS 214 N. Potomac St. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/62		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR APR 19 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05149

05147

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		d. STREET ADDRESS <u>866 Dewey Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Knodel</u> Last <u>Zeller Sr.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 31, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor & Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Houses</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Mt. Morris, Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph H. Zeller</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Ann Knodel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>214-34-0002</u>		17. INFORMANT <u>Mrs. H. K. Zeller</u> Address <u>866 Dewey Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6</u> , 19 <u>61</u> , to <u>April 18</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>April 18</u> , 19 <u>62</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.		22b. DATE SIGNED <u>4/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22d. ADDRESS <u>214 N. Potomac St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR <u>APR 23 '62</u> DATE	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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CHARTER OF 1875

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